Paternal Depression: Manifestations and Impacts on the Family

by

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A doctoral project submitted to the faculty of the

California School of Professional Psychology

in partial fulfillment of the requirements for the degree of

Doctor of Psychology at

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The doctoral project of Elizabeth Newmark, M.A., directed and approved
by the candidate's Committee, has been accepted by the
Faculty of the California School of Professional Psychology
in partial fulfillment of the requirement for the Degree of

DOCTOR OF PSYCHOLOGY

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DEDICATION

This project is dedicated to the fathers who have opened their homes, hearts, and minds to me over the past three years, and have so graciously allowing me to work with their families and children. You have all taught me so much about life, family, love, and sacrifice. You are strong, you are admirable, and you matter.

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ABSTRACT

Depression is a serious mental disorder with prominence in the literature, but information on its manifestation in males has been overlooked until fairly recently. Attention should be paid to depression for several reasons, including the risk of suicide. The presentation of depressed males differs from that of depressed females. They may display additional symptoms not typically associated with depression, such as anger, hostility, withdrawal and substance abuse, and may not show sadness or tearfulness. Men's reluctance to seek help, and the strong association between shame and depression, make detection even more difficult. Research suggested that families in which fathers display negativistic parenting practices, such as hostility and low levels of warmth, suffer undesirable outcomes. Conflict resolution strategies may be impaired in depressed men, and there is research available showing that depression is correlated with marital discord. Men with depression may also be at risk for substance abuse disorders, intimate partner violence, and child maltreatment. Cultural factors may affect manifestation of depression, and cultural background and adherences should be considered when working with depressed men.

CHAPTER I

Introduction

Maternal depression has been the focus of intense scrutiny, and negative ramifications and potential for psychopathology of maternal depression on children have been well documented. Extensive research has suggested that children of depressed mothers have experienced both internalizing and externalizing symptoms (Goodman et al., 2011), and that children's symptoms have been most likely to improve when mothers' depressive symptoms have been addressed and treated (Nicholson, Deboech, Farris, Boker, & Borkowski, 2011; van Loon, Granic, & Engels, 2011). The literature has illustrated a sense of urgency regarding maternal depression and its contributions, while research conveying a similar sense of urgency surrounding the effects of paternal depression on child and family outcomes has been relatively recent. A review of the literature on the impact of fathers on the outcomes of their children and families is needed, in order to help mental health professionals shift their attention toward the significance and unique contributions of fathers within families. Why has there been a relative abundance of attention directed toward maternal depression over paternal depression? This question can be answered using personal experience in the mental health field, and deduced from new information emerging regarding the manifestation and clinical issues involved in male depression.

In my experience in community mental health, I have witnessed an undercurrent of bias regarding mothers as primary caregivers, and fathers as secondary in the care of their children. This dynamic has displayed itself in several areas. Therapists have often

contacted families and asked for the mother and child to attend intake and assessment, and at times have neglected to ask if fathers have been available to join sessions. Mothers have typically been listed as primary caregivers in clients' records. Additionally, fathers with depression may have appeared more hostile and irritable than females with depression (Chuick et al., 2009; Cochran & Rabinowitz, 2003; Wexler, 2009), and may not have wished to violate cultural norms exalting strength and provision to let others know that they were suffering (Addis & Mahalik, 2003). This has presented unique clinical challenges within the context of family therapy and may have even deterred therapists from engaging these fathers sufficiently. Mental health professionals may have shied away from involving a hostile, irritable, or withdrawn father in children's treatment, though this may have been the very relationship that required professional help to begin healing.

Male depression in general has been overlooked for several reasons. This literature review urged readers to identify more subtle or atypical presentations of depression in men and to reconsider the significance of fathers in the lives of their children. Specifically, when fathers have been depressed, family dynamics may have been altered, relationships may have been strained, child outcomes may have been less optimistic, and family functioning may have degraded significantly if not addressed (Elgar, Mills, McGrath, Waschbusch, & Brownridge, 2007; Gartstein & Fagot, 2003; George, Herman, & Ostrander, 2006; Kane & Garber, 2008). Because male depression often has not manifested as the classic or overt symptomatology presented in the fourth edition, text revision of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000), mental

health professionals should be educated on the ways that depression has been displayed in men. With a thorough understanding of male depression, mental health professionals may be able to identify, address, and treat it within affected individuals and families.

Goals and Objectives

The general intention of this literature review was not to place or shift blame of poor child outcomes from one parent to another, but to illuminate both the individual and systemic struggles that have accompanied men and their families when they have suffered from depression. My goal was to help families learn the tools to function in a healthy manner, with warmth, engagement, communication and structure. In order for this to occur, mental health professionals must be equipped with a clinical discernment to identify the presence of depression in men and of clinically appropriate ways to handle it within therapy.

There were two specific goals of this literature review. The first goal was to explain the manifestation and presentation of depression specific to males, and discuss cultural, personal, and societal issues that have kept male depression somewhat concealed from the general public. Without understanding of these issues and of the typical presentation of men with depression, mental health professionals will be limited in their effectiveness in treating afflicted individuals and families. The second goal was to offer insight into the complexity of family dynamics and interpersonal stress that have accompanied male depression, and to explain the underlying mechanisms of family discord when paternal depression has been present. The research presented underscored the effects that paternal depression can have on family relationships, marriages, problem solving, connectedness, attitudes and relational patterns, as well as behaviors and

personal conduct. The research also highlighted cultural factors that have affected the presentation and ramifications of depression in men. The research presented in this literature review identified challenging interpersonal dynamics and patterns of behavior typically seen in families with a depressed father, so that depression may be identified and addressed appropriately. It is important for mental health professionals to give credence to the struggles endured by depressed fathers, and to avoid misdiagnosis of the symptoms, so that healing may begin.

CHAPTER II

Review of the Literature

Overview of Depression in Men

The *DSM-IV-TR* (APA, 2000) contained a list of Depressive Disorders under the broader category of mood disorders. Depressive Disorders in the *DSM-IV-TR* (APA, 2000) were Dysthymic Disorder, Major Depressive Disorder (recurrent or single episode, with specifiers), and Depressive Disorder Not Otherwise Specified. Dysthymic Disorder has been marked by two or more years of experiencing depressed mood more often than not, and presence of at least two of five additional depressive symptoms while depressed. The diagnosis has required that the individual has not had a major depressive episode during the first two years of symptoms. Major Depressive Disorder has included the presence of at least one Major Depressive Episode, marked by at least five of nine specific depressive symptoms, accompanied by either depressed mood or loss of pleasure or interest, and not be the result of a medical condition or substance. Those with Depressive Disorders have never had a Manic, Mixed, or Hypomanic episode; presence of Manic, Mixed, or Hypomanic Episode has qualified an individual for another mood disorder, like Bipolar Disorder or Cyclothymic Disorder. The diagnosis of Depressive Disorder Not Otherwise Specified has been given when an individual has experienced clinically significant depressive symptoms, but has not met full criteria for Dysthymic Disorder or Major Depressive Disorder (APA, 2000).

The *DSM-IV-TR* (APA, 2000) has provided helpful guidelines in diagnosing Depressive Disorders, but has often failed to capture the experience of what Wexler

(2009) has called "*Male-Type Depression*" (pp. 130-131), also referred to as male depressive disorder, covert depression, or depression-male type. Depressed men have often gone undiagnosed because they reported symptoms other than sadness, such as fatigue, irritability, restlessness, somatic symptoms, insomnia, emptiness, feelings of being "dead inside" (Wexler, 2009, p. 131) and a decline in vitality. Though generalizations have always failed to capture the experience of every member of a group, behaviors of men who have experienced male-type depression have tended to be different from behaviors of depressed women. Wexler (2009) noted that depressed men have often engaged in antagonistic behaviors and placing blame on others. For example, they may have experienced angry outbursts; created conflict; felt guarded; or thought that it was the responsibility of another person to change so that they could solve their problems. They have also tended to engage in "exaggerated hypermasculine behavior" (Wexler, 2009, p. 133) to combat the presence of what they have perceived to be signs of weakness or vulnerability within themselves. These hypermasculine behaviors can include overemphasis on finding solutions, displays of hypersexuality, workaholism, assertions of independence, and overall attempts to project the image of strength and control. Wexler (2009) found that avoidance of emotional content or feelings of weakness has also been part of male-type depression, such as not wanting to talk about sadness or weakness, disruption in relationships, being unable to assign language to feelings, and use of distractions (e.g., television, the Internet, video games, alcohol, or sex) to fight off the negative experiences. Lastly, there has been a component of male-type depression that involves discontentment with the self. Depressed men have tended to be extremely

sensitive to shame and fear it immensely. They have focused on perceived failure and have been critical of themselves and their actions (Wexler, 2009).

It is crucial to identify the diverse presentations of depression, especially in the male population, in light of statistics concerning suicide. Part of the diagnosis of a depressive disorder may have been the presence of suicidal thoughts or actions (APA, 2000), and the American Association of Suicidology (2010) stated that out of those who have completed suicide, 2/3 were depressed at their time of death. According to Crosby, Han, Ortega, Parks, and Gfoerer (2011), during 2008-2009, there were an estimated 477,000 adult male suicide attempts in the U.S., and an estimated 616,000 adult female suicide attempts. While women have been more likely to experience suicidal thoughts and to attempt suicide, men have been about four times more likely to complete suicide (American Association of Suicidology, 2010; Crosby et al., 2011).

Reasons for neglect of male depression. Several researchers have speculated about the reasons why men have been somewhat neglected in the study of depression. Cochran and Rabinowitz (2003) noted the reluctance of men to display or express the emotions associated with depression, something that women have tended to do with more ease. Cultural norms have been powerful in dictating men's level of comfort with sharing the sadness they experience. Rather than sadness, men have tended to express anger, display withdrawal, and use alcohol to self-medicate – all things that can cover up a depressive episode and make it difficult to detect (Cochran & Rabinowitz, 2003).

Addis (2008) took a different and somewhat controversial stand; he considered demographic factors when reviewing the research available on the study of depression. He equated the lack of focus on men in the study of gender to an exclusion of white

individuals from the study of race and ethnicity, describing dominant group members as the baseline against which non-dominant group members are compared. From this viewpoint, the male experience has been one that those examining women have used as a benchmark for evaluation and examination of their experiences – an explanation that has essentially left men without a benchmark for examination of themselves.

Nevertheless, Addis (2008) outlined four frameworks for understanding depression as it has related to the male experience, in an effort to illuminate gender-sensitive conceptualization. These frameworks have provided context about how society has tended to view male depression, and propose possible mechanisms for the development and experience of depression while taking into account gender differences. The *sex differences framework* suggested that the difference in presentation of depression in men and women has been due to differences in the natural phenotypic makeup of men and women, rather than a construct that guides men and women to present differently. The *masked depression framework* pinpointed gender socialization as the main reason that men have concealed their depressive experiences and symptoms. It emphasized cultural masculine norms of "antifemininity, competitiveness, homophobia, emotional stoicism, self-reliance, physical toughness, financial success, and power over women" (Addis, 2008, p. 157). Men's level of adherence to these norms may have dictated how they responded when depression occurred, causing some to try to hide, or mask, their symptoms.

The *masculine depression framework* assumed that cultural masculine norms have been restrictive to men, and have caused significant strain in boys and men attempting unsuccessfully to conform to these norms (Pleck, as cited in Addis, 2008). The strain

caused by an inability to meet impossible standards has led to psychological difficulties such as depression, according to this framework and literature reviewed by Addis and Mahalik (2003). The *gendered responding framework* differed from the masked depression framework in that it assumed that masculinity has affected men's responses to all affect, not just depression as outlined in the *DSM-IV-TR* (APA, 2000).

Symptoms. Angst et al. (2002) reviewed a multitude of articles suggesting that the prevalence of Major Depressive Disorder among females was twice as high as the prevalence among men. Fortunately, the authors noted that this finding might have been distorted by the higher prevalence of treatment seeking by women as compared to men. The research team sought to delve deeper by choosing to examine the details of depression within each gender, such as symptoms, management of symptoms, attributions regarding cause of symptoms, and help-seeking to see if gender differences would emerge (Angst et al., 2002). The study included 38,434 males and 40,024 females, all randomly selected from six countries: Belgium, France, Germany, The Netherlands, Spain, and the United Kingdom. Participants were given screening tools and questionnaires to assess presence, severity, and other details related to depression. Participants who had suffered from depression and had sought help from a professional for their depression were then assessed. This group included 1884 participants (563 males and 1321 females).

Symptoms reported by the depressed participants varied by gender (Angst et al., 2002). More women than men reported: fatigue, sleep problems, changes in appetite, palpitations and tearfulness/emotionality; more men than women reported increase in the need to drink alcohol. Participants significantly attributed causes of depression to outside

stressors. Men attributed their depression to physical illness/problems and problems at work with more prevalence than did women, and women attributed their depression to relational problems (illness/death in family, relationship problems, and pregnancy/giving birth) with more prevalence than did men. Functional impairments differed as well. Men reported more difficulty in their ability to work, while women reported perception of poor general health quality and sleep difficulties more often (Angst et al., 2002).

Angst et al. (2002) found that coping for both sexes included reaching out to family and friends for support. However, some differences in coping strategies varied between genders. While women often coped with depression through emotional displays (e.g., laughing, crying) and through religion, men tended to cope through engaging in sports/hobbies and substance use (alcohol and cigarettes). Sixty-five percent of the second wave participants reported medical conditions, with men reporting significantly more heart disease and diabetes, and women reporting significantly more migraine and thyroid problems (Angst et al., 2002).

Chuick et al. (2009) conducted a qualitative study to investigate the experiences of depressed men. The research team consisted of one 57-year-old licensed psychologist and four 26- to 37-year-old psychology doctoral students at Midwestern University; all team members had a background in the study of men and masculinity. All were European American and from middle to upper-middle class backgrounds. All were male except for one female doctoral student. Participants were found using advertisements, which were put into a local hospital newsletter, and also at various community locations such as grocery stores, buses, and bulletin boards in retail stores. Fifteen male participants were included in this study; thirteen identified as heterosexual, one identified as bisexual and

one identified as gay. One participant identified as Native American and the other 14 identified as European American; ages ranged from mid-20s to mid-70s. Ten participants reported being married, three reported being partnered and two reported being single. Participants' salaries ranged from $15,000 to $75,000 annually. Participants were interviewed for the first time in-person and were asked to participate in a follow-up interview in-person eight months later. Participants were compensated $15 for each interview. All 15 participated in the first interview, and seven participated in the second interview. The eight that did not participate in the second interview were either unable to be reached or declined to participate. The research team used open coding, axial coding, and selective coding to identify themes and categories of experience discussed by participants (Chuick et al., 2009).

Most of the participants in the study reported that the onset of their depression occurred at the time of a significant life change, such as transitions, losses, work changes, or relocation (Chuick et al., 2009). They reported typical symptoms of depression as listed in the *DSM-IV-TR* (APA, 2000), including lack of interest in previously enjoyed activities, sleep problems, fatigue, mood disturbance (often described as "not feeling good"; Chuick et al., 2009, p. 306), and thoughts of death. However, other symptoms were commonly reported as well, including physiological symptoms of stress, anger, irritability, and interpersonal disturbance. Participants tended to report that symptoms of depression were worsened by both environmental factors and personal factors (i.e., their own maladaptive coping skills). Maladaptive coping skills, which tended to be short-term remedies, included substance abuse, infidelity in intimate relationships, withdrawal, avoidance, denial, and suicidal ideation. Participants also identified factors that helped to

alleviate their depression, including access to treatment, feeling as though they could safely express feelings, supportive interpersonal relationships and normalization (Chuick et al., 2009). Psychotropic medication, therapy (individual, group, and couples), and religious counseling tended to produce long-term alleviation of depression.

Chuick et al.'s (2009) study also included considerations related to the role of masculinity in depression. Many participants reported feeling that depression is socially unacceptable for men, as is seeking help, and that weakness has been perceived when men struggle with depression. They noted that support for depressed men has been insufficient. This was a difficult dynamic with which to grapple when participants also reported that they felt pressured to hide their depression (Chuick et al., 2009). It is important to note that because this study was qualitative in nature, results cannot be generalized to the population. However, the results provided several topics to explore in greater depth with larger, quantitative studies.

Help-seeking. Addis and Mahalik (2003) reviewed the literature and found evidence that men across different age groups, nationalities, and ethnic and racial backgrounds have been less likely to seek help from professionals for physical care, psychiatry, counseling, and substance abuse treatment than are women. The literature they reviewed also included self-reports by men stating that they would be more hesitant to seek assistance, even from peers, with some stating that they would never seek services to address depression. The result of refusal or reluctance to seek help may have led to an under-detection of depression in men.

In addition to the elusive conceptualization of male depression in general, the low rate of help-seeking among men may have developed into a perception that men are less

affected by depression than are women. Addis and Mahalik (2003) shared an excellent example of the cultural norms associated with masculinity in male athletes. They noted that male athletes who refrain from expressing the severe pain of an injury and continue to compete "are typically applauded for their *intensity*, *commitment*, *heart*, or *toughness*. These labels reinforce the identification of emotional stoicism and physical toughness with positive aspects of masculinity while discouraging self-care in the context of an injury" (Addis & Mahalik, 2003, p. 9). If the language used to describe an avoidance of expression of physical pain references strength and power, men may internalize the idea that expression of that pain correlates with weakness. Additionally, self-care is avoided, which likely compounds the loneliness and isolation already experienced from emotional pain. In the midst of emotional suffering, men are rewarded for being tough as they suppress the pain.

Joiner et al. (1992) conducted a study to examine the relationship and dynamics related to depression, self-esteem, and *reassurance-seeking* (i.e., seeking reassurance that others genuinely care). Participants were 353 students at the University of Texas at Austin: 188 women and 165 men. The participants' roommates participated as well, and 15 participants were excluded because their roommates were of the opposite sex. Excluding opposite-sex roommates was an attempt to maintain the uniformity of the sample; all remaining participants had roommates of the same sex. During a first visit, the participants completed several questionnaires (i.e., Beck Depression Inventory [BDI], Depressive Interpersonal Relationships Inventory, and Rosenberg Self-Esteem Questionnaire). During a second visit five weeks later, roommates were administered the following questionnaires: BDI, Emotional Empathy Scale, Reaction to Dependent Others

Scale, Evaluation of Target on Revision of Rosenberg Self-Esteem Questionnaire, and Desire to Change Roommates (a one-item questionnaire using a scale to inquire about intensity of desire to change roommates during the next term).

Several findings emerged from this study. First, depression was related to higher likelihood of reassurance-seeking. Second, rejection was not inherently a consequence of depression, but rejection was more likely to occur if depressed individuals sought reassurance. Rejection was not likely when a depressed man with low self-esteem did not seek reassurance. Third, depressed male subjects with low self-esteem and high levels of seeking reassurance tended to have roommates who were also depressed. Last, the interpersonal style of roommates (supportive or unsupportive of "dependent behavior"; Joiner et al., 1992, p. 171) was significant in predicting the rejection of depressed men. Rejection was not the predictable result of depression, low self-esteem and high reassurance-seeking when roommates were inclined to a supportive style, but rejection was much more likely if roommates tended toward an unsupportive style. In this article, Joiner et al. (1992) highlighted the potential contagious nature of depression and the possible expectation that depressed men should "'suffer in silence' and 'take it like a man'" (Joiner et al., 1992, p. 171).

Shame and depression. Shame has appeared to be a significant factor in the experience of depression in men, and the correlation between depression and shame has been researched and affirmed (Cheung, Gilbert, & Irons, 2004; Wright, O'Leary, & Balkin, 1989). It is important to first distinguish shame from guilt. The focus of guilt is behavior, and reflects an internalized moral code about how to behave (Brown, 2012; Lester, 1998). Shame is a much more global experience. It involves a focus on the core of

the self as defective, rather than one's actions (Brown, 2012). Lester (1998) noted that one who feels shame may seek secrecy and avoid others, rather than taking corrective action. While shame has been highly positively correlated with a host of maladaptive behaviors (e.g. addiction, depression, aggression, eating disorders, violence bullying, and suicide), guilt has been negatively correlated with these behaviors (Brown, 2012). Results of Lester's (1998) study echoed that the correlation between feelings of shame and current suicidality was much stronger than the correlation between guilt and current suicidality.

A study by Ashby, Rice and Martin (2006) found that, while self-esteem and shame both played a role in the relationship between maladaptive perfectionism and depression for women, shame was the sole mediator between perfectionism and depression in men. In other words, perfectionism appeared to have an adverse effect on self-esteem in men, but did not affect the development of depression. However, perfectionism in men led to depression through the vehicle of shame. Cheung et al. (2004) discovered that men who feel shame ruminate more than women who feel shame. A study by Wright et al. (1989) showed that shame and guilt were both correlated with depression, and that the shame-depression association was stronger than the guilt-depression correlation. However, shame may have unexpected behavioral manifestations. Depressed men may be experiencing a variety of negative self-beliefs (that they are unloved, unwanted, unacceptable), and may try to defend against these feelings by displaying narcissistic behaviors (Wright et al., 1989). This has helped to explain the gender differences in the presentation of, and coping with, depression.

In her TED Talk, Brown (2012) outlined gender differences in the experience of shame. She stated that while shame feels the same in men and women, gender organizes people's experiences of shame. The expectation for women has been to "do it all, do it perfectly, and never let them see you sweat" (Brown, 2012, n.p.) and women have experienced shame as a result of an inability to reach nearly impossible standards in competing and conflicting areas. Conversely, men have tended to have only one societal expectation, which has been to never be perceived as weak, and men have experienced shame when they feel or display weakness. Brown (2012) also highlighted the significant impact of women in the perpetuation of the expectation of men to conceal anything that may be perceived as weakness. Women can be most powerful in their efforts to support the men in their lives by sitting with them and listening to their vulnerability without judgment. Three salient contributors to growing shame have been secrecy, silence, and judgment, and a strong antidote has been empathy (Brown, 2012). To help men who are experiencing shame, those around them must address it openly with empathy, and refrain from criticism and judgment. This is particularly important in light of the negative correlation between shame and self-compassion shown by Reilly, Rochlen, and Awad (2013). Men experiencing shame are likely already berating themselves, so families and mental health professionals can intervene by offering compassion.

Previously attempted interventions. The National Institute of Mental Health developed a unique intervention in April 2003 intended to target depressed males through community outreach, called *Real Men. Real Depression* (RMRD; Rochlen, Whilde, & Hoyer, 2005). Public service announcements (PSAs) on television reached roughly 34 million people, and 8 million people visited the campaign's website (Rochlen et al.,

2005). The main slogan of the campaign was, "It takes courage to ask for help. These men did" (Rochlen et al., 2005, p. 188)

The RMRD campaign was intended to increase public awareness about depression in the male population and to enhance quality of mental health services available to men with depression (Rochlen et al., 2005). PSAs included clips of interviews of men with histories of depression discussing their experiences with the illness. Focus groups, including men of various ages, helped to determine which of the PSAs were most relevant and representative. These PSAs were shown on television. Other forms of media and mass communication were utilized as well, including print (i.e., brochures), radio, and an interactive website. There was also a hotline available for the public to call if needed (Rochlen et al., 2005). Brochures, pamphlets and other print-based materials provided extensive psychoeducation about depression in men, encouraged help-seeking for those affected, provided community resources, and outlined research related to depression in men. The website included tabs on which users could click and receive information, including an overview of depression in men, symptoms, treatment, personal stories from men who have suffered from depression.

Rochlen, McKelley, and Pituch (2006) examined the impact of the RMRD campaign as compared to other non-gender-specific materials regarding depression in a quantitative study at a large Southwestern university. Participants were 209 male college students, ages 18-27, who would receive course credit for participation. Forty-five percent of the participants were European American, 28.6% were Asian American, 16.7% were Latino American, 3% were Indian American, 2% were multiracial, 1.5% were African American, and 2% identified as Other. Fifty-five percent of participants

were seniors, 18.7% were juniors, 18.7% were sophomores, 6.9% were freshmen, and 0.5% were graduate students. When asked to report previous experience in therapy or counseling, 12.8% of the men responded in the affirmative, and 3.9% reported having received treatment for depression. Participants reviewed one of three brochures; one brochure was made specifically for the RMRD campaign, and a second brochure was the same format, but altered to remove gender specificity. Brochure 1 was called "Real Men. Real Depression" and contained pictures and statistics related to men, while Brochure 2 was called "Real People. Real Depression" and contained pictures and statistics related to both men and women. A third brochure was used as well, called "Beyond Sadness," which outlined symptoms of depression in addition to options for mental health treatment. Participants then completed demographic questionnaires and quantitative measures to assess gender role conflict and attitudes toward seeking psychological help, and a five-item scale assessing effectiveness of brochures specifically for the field of mental health. Qualitative, open-ended questions were also asked of participants to allow them to discuss various aspects of the advertising strategy (Rochlen et al., 2006).

Findings showed a three-way interaction between gender role conflict, help-seeking attitudes and brochure type, such that men with low levels of gender role conflict and poor attitudes toward help-seeing found the male-specific brochure more appealing (Rochlen et al., 2006). However, this was the only group that rated the men's brochure more favorably, while all others rated the three brochures with equal favor. Through examination of participants' qualitative responses, researchers gathered information about elements that participants thought were helpful components of the brochures, in addition to elements that participants thought were unhelpful. The helpful elements,

according to participants, were symptom lists, quotes and testimonials of those affected by depression, and general information about depression. Though many participants noted that there was nothing unhelpful about the brochures, the elements that were rated most unhelpful were presentation factors (e.g., layout, tone of writing, etc.) and Other (Rochlen et al., 2006). While qualitative analyses of participants' responses may have provided a platform from which to base further research, this study was not generalizable. It also only described which brochure was most appealing to participants, and did not address behavioral results. It was not reported how many of the participants sought treatment following the study, an important variable to consider when studying the effectiveness of this campaign.

Depressed Fathers as Parents

Parenting styles. ***Family environment.*** Elgar et al. (2007) reviewed the literature on parenting styles of depressed parents, and found that various negative parenting practices were more commonly utilized by depressed parents than non-depressed parents, such as intrusiveness, hostility, neglect, low involvement, and low warmth. In this section, parenting styles of depressed men was outlined more extensively. Reviewed research suggested general tendencies of depressed fathers, and family dynamics were discussed as they relate to depression in fathers and child development.

In a study investigating the connection between family environment and child psychopathology, George et al. (2006) looked specifically at symptoms of depression, externalizing behaviors, and inattention/hyperactivity in children as related to the family environment. Participants were 362 first, second, third, and fourth grade children from 22 elementary schools. The Hyperactivity Index on the Revised Conners Rating Scale was

used to determine whether a child exhibited "problematic" behaviors in a variety of settings. The 232 participating children who scored above 1.75 standard deviations from the mean were identified by parents and teachers as having symptoms of inattention/hyperactivity (i.e., restlessness, distractibility), conduct disturbance (i.e., tantrums, unpredictability), or internalizing symptoms (i.e., mood swings, sulking). These children were compared to a comparison group of 130 children who scored close to the mean on the Hyperactivity Index, had never used psychotropic medication, and had no history of being assessed for behavioral difficulties. Measures included the Family Environment Scale to measure family characteristics, and the Behavioral Assessment Scale for Children (i.e., self-, parent-, and teacher reports). Following univariate analyses of individual variables, researchers used hierarchical regression analyses to examine the relationship between ten family variables, while controlling for potential confounding variables (i.e., age, SES, and general psychopathology). Then, potential interaction terms were examined by adding these items to the regression to see if they interacted with age, SES, or general psychopathology. Corrections were made to reduce error.

Results showed that the parenting practices used by depressed parents were precisely the practices that were found to lead to child maladjustment (George et al., 2006). Findings suggested that low levels of family cohesion, cultural/intellectual/ recreational activities, and independence, in addition to high levels of family conflict and control, predicted higher levels of depression in children. While inattention/hyperactivity symptoms were not found to correlate with family environment, conduct problems in children were found to exist more frequently in families with low cohesion, low

orientation to intellectual/cultural pursuits, and high levels of conflict (George et al., 2006).

Gartstein and Fagot (2003) were interested in examining children's externalizing behavior as connected to parental depressive symptoms, factors relating to family and parenting, and child effortful control (i.e., a child's ability to exercise self-regulation). Externalizing behaviors were defined as aggressive and noncompliant behaviors, and were measured using the Child Behavior Checklist (CBCL). Additionally, these researchers studied the unique effects of parenting by mothers and fathers on child outcomes. Gartstein and Fagot (2003) reviewed the literature and found mixed evidence for unique effects of mothering vs. fathering on child outcomes. Participants were 159 children, 83 girls and 76 boys, and their families from Lane County, Oregon. The study took place between August, 1986 and March, 1988. Criteria to participate included two-parent families in which there was the presence of a five-year-old child (participant) in the home and the presence of a father in the home. Participants were respondents to advertisements in local newspapers. The age of mothers ranged from 23 to 44 years (M = 32.27), and the age of fathers ranged from 18 to 67 years (M = 34.86). The median income of the families was $21,000, which was $7,400 below the median income for Lane County. For level of education, fathers most frequently reported having some college. Twenty-five percent of fathers and 15% of mothers had attended or completed graduate level education. Ninety-two percent of the children were European American, 5% were African American, 1.1% were Asian American, 1.6% were Latino American, 0.5% were Native American, and 3.7% were multiracial. Participants were asked to complete an interview regarding demographic information, a Q-sort task (not included in

this study), the Center for Epidemiological Studies Depression Scale, the CBCL, the Child Behavior Questionnaire, the Family Events Checklist, the Dyadic Adjustment Scale, a home study, and an in-laboratory observation of parenting styles. Coercive parenting behaviors were assessed with the Fagot Interactive Code. Data were collected from both mothers and fathers (Gartstein & Fagot, 2003).

Researchers used hierarchical multiple regression analyses to examine how strongly depressive symptoms, parenting, family adjustment, and child effortful control impacted child externalizing behaviors (Gartstein & Fagot, 2003). Potential interactions were considered between child effortful control and three variables (parental coercion, marital/family adjustment, and parental guidance). Though no interactions appeared present, main effects of several variables on child externalizing behaviors were present, and varied by parent gender. For mothers, child-externalizing behavior was correlated with depressive symptoms, coercion, cognitive guidance, and child effortful control. For fathers, child-externalizing behavior was correlated with depressive symptoms, marital/family stress, and child effortful control (Gartstein & Fagot, 2003). Similarly, Marchand and Hock (1998) studied the correlation between parental depressive symptoms and preschoolers' maladjustment, and found support for the correlation between depressive symptoms in fathers and child internalizing behaviors.

A study by Elgar et al. (2007) addressed mothers' and fathers' depressive symptoms and child maladjustment with a specific focus on the contribution of parents' behaviors as mediators. The researchers predicted that parents' depressive symptoms, nurturing behavior, rejection, monitoring, and all areas of child maladjustment would be related with each other. They also predicted that depressive symptoms in parents and

child outcomes would be mediated by parenting behaviors. Data were obtained from participants in the National Longitudinal Survey of Children and Youth, which was conducted by the Canadian government from 1998-2000 (Elgar et al., 2007). Participating families chose which parent was to participate in phone interviews, which yielded mostly mothers and an underrepresentation of fathers. The interviews assessed for parental depression and gathered demographic information. Questionnaires were also administered to participating children at their schools to evaluate their internalizing, externalizing, and social behavior, as well as their relationships with their parents. A total of 4,184 families participated, including 3,854 mothers and 330 fathers. The majority of participants (51.9%) identified as Canadian, with 35.3% identifying as British, 27.4% as French, 25.1% as European, 4.3% as North American Indian, Métis, or Inuit, 3.2% as Chinese or South Asian, and 1.4% as Black or African. Hierarchical linear modeling was used to analyze data (Elgar et al., 2007).

Results suggested that parenting practices acted significantly as mediators between parental depressive symptoms and child maladjustment (Elgar et al., 2007). Specifically, parental nurturance was a mediator between parental depressive symptoms and children's externalizing and social behavior, parental rejection was a mediator between parental depressive symptoms and children's issues with internalizing and externalizing, and parental monitoring was a mediator between parental depressive symptoms and their children's internalizing problems and social behavior (Elgar et al., 2007).

The family environment has been an important factor in child outcomes. Paternal depressive symptomatology may have negative ramifications, but relational elements

may worsen or alleviate those negative effects. Depressed parents have tended to engage in specific parenting practices, such as low levels of cohesion and cultural or intellectual activities, and high levels of conflict and control. These practices have been predictive of depressive symptoms and conduct problems in children (George et al., 2006). Children with externalizing behaviors have tended to come from families in which there was marital conflict, parental depressive symptoms, and little room for the child to exercise self-regulation (Gartstein & Fagot, 2003). However, when parents have been depressed, their ability to nurture their children may have alleviated the effects of depression on the child's outcomes. If depressed parents have shown rejection to their children, it may have led to both internalizing and externalizing problems in children (Elgar et al., 2007). This research showed that while paternal depression may have consequences for child behavioral problems, positive family environment characteristics can offset these consequences.

Positivity and negativity in parenting. Jacob and Johnson (2001) examined the link between depression in fathers and positivity suppression in their parenting. Positivity suppression was defined as an individual responding with negativity (or lack of positivity) to a positive remark made by another individual. The researchers also studied the connection between these parenting practices and child outcomes to see whether relational patterns between these parents and their children would be connected to maladjustment in the children (Jacob & Johnson, 2011). The study included families with a depressed mother, families with a depressed father, and families with non-depressed parents in order to look for differences in child adjustment and relational patterns between fathers and mothers with their children.

Jacob and Johnson (2001) found that families specifically with depressed fathers showed more interactions including positivity suppression than did families with non-depressed parents or families with a depressed mother, indicating a unique effect of paternal depression on family relations. In families with depressed fathers, interactions between a non-depressed mother and child included higher rates than other families of positivity suppression even without the depressed father present (Jacob & Johnson, 2001).

A meta-analysis by Wilson and Durbin (2010) included 28 studies examining depressive symptoms or diagnoses in fathers and parenting behaviors. The researchers categorized parenting behaviors as positive or negative. Positive parenting behaviors included interactions that incorporated warmth, sensitivity, acceptance, support, engagement and affection, while negative behaviors included interactions in which coercion, criticism, negativity, excessive control, restriction, or hostility were present (Wilson & Durbin, 2010). Paternal depression was associated with decreased levels of positive parenting behaviors and increased levels of negative parenting behaviors. Age of both child and father had moderating effects on the association between fathers' depressive symptoms and parenting behaviors. Negative parenting behaviors were more strongly associated with depression in fathers when either child or father was younger. Depression in fathers was also associated with more negative parenting behaviors in non-European American families, though sufficient information regarding extraneous variables such as socioeconomic status of these families was unavailable. Methodological factors also acted as moderators. For example, negative parenting behaviors and depressive symptoms in fathers were more strongly correlated when fathers completed self-report measures than when fathers were scored by others based on observation,

indicating potential differences between depressed fathers' perception of their own parenting and others' perceptions of their parenting. An additional moderating factor was the length of time of observations, as longer assessments were related to stronger correlations of depressive symptoms and negative parenting behaviors (Wilson & Durbin, 2010).

Depression in fathers has had a unique correlation with positivity suppression. Families with a depressed father have been more vulnerable to positivity suppression than families in which neither parent was depressed and families with a depressed mother (Jacob & Johnson, 2001). Wilson and Durbin (2010) also found similar positivity suppression in families with depressed fathers, in addition to an increase in negative behaviors, such as hostility and criticism. This was not surprising, given the male-specific symptomatology of depression, including fatigue, feelings of emptiness or being "dead inside" (Wexler, 2009, p. 131), and irritability. This research demonstrated the importance of treatment of paternal depression, not only because of the potential benefit to fathers, but also for the purpose of constructively altering parenting practices to include warmth and positive engagement.

Problem solving. Research by Chuick et al. (2009) highlighted the tendency of depressed men to use maladaptive coping skills (e.g., relational infidelity, withdrawal, substance abuse, denial, and suicidal ideation) rather than constructive, healthy problem solving to deal with their depression. Miller, Murry, and Brody (2005) examined fathers' problem solving skills and their link with child outcomes through self-report and teacher report measures of preadolescents. The results of the study suggested that positive problem solving by fathers is inversely related to children's social withdrawal.

Additionally significant was the finding that the problem solving demonstrated by mothers and the social withdrawal of children were not correlated, further illustrating the unique effect that fathers have in relationship with their children. Interestingly, boys benefited more strongly than girls in the area of sociability when fathers assisted with positive problem solving. When fathers were more engaged in constructive problem solving, children became less socially withdrawn, a finding that was gender specific to men (Miller et al., 2005). Fathers have had a unique opportunity to impact their children's social development through modeling adaptive problem solving skills.

Child emotionality. The parenting strategies that fathers have used to handle their children's expression of emotion may have affected child outcomes. Dittman et al. (2011) examined the connections between parent emotionality, prevalence and effectiveness of parenting strategies used to address distressed behavior in children between the ages of four and seven years old, and child responses and emotional symptoms. Emotional distress was assessed using the five-item Emotional Symptoms scale on the Strengths and Difficulties Questionnaire, along with questions addressing separation anxiety disorder, social phobia, and specific phobia. Results indicated that use of physical contact and speaking in a soothing voice were commonly used to respond to a distressed child, along with allowing a child to avoid anxiety-inducing situations. There was a distinction between mothers and fathers in the effectiveness of parenting approaches to child distress. Use of physical contact by mothers to soothe child was a predictor of more healthy child emotional adjustment, and children were found to be least likely to have high levels of internalizing symptoms when fathers encouraged bravery in children. Interestingly,

depression and stress in fathers appeared to have no correlation with child emotional distress (Dittman et al., 2011).

Emotion socialization may play a large role in child outcomes. Hunter et al. (2011) studied the connection between parents' meta-emotion philosophies (MEP; defined by the researchers as "thoughts, reactions, and feelings about their own emotions"; p. 428) and the MEP of their adolescent children. MEP was measured through a semi-structured interview and based on self-report. In addition to parents' MEP and adolescents' MEP, the MEP of parents regarding their children (e.g., how parents think, feel, and react to their children's emotions) was also measured. This sample included 152 adolescents aged 14-18 and their parents. The majority of the sample was of middle socioeconomic status, and 82% of the participants were European American (Hunter et al., 2011).

Hunter et al. (2011) found that parents' child-directed MEP was positively correlated with adolescents' MEP, but parents' self-directed MEP was not correlated with adolescents' MEP. Essentially, adolescents' perceptions and ideas about their own feelings was impacted by the way their parents coached and guided them to think about their emotions, but not impacted by parents' self-perceptions and ideas of emotions. This finding had mixed support, as Katz and Hunter (2007) found that maternal self-directed MEP was correlated with adolescent outcomes. Intriguingly, fathers' child-directed MEP were significant predictors of adolescents' MEP even when controlling for parental depression and maternal MEP, but mothers' child-directed MEP did not significantly predict adolescents' MEP when controlling for paternal MEP (Hunter et al., 2011). This suggested that the ways parents perceive and think about their child's emotions, and the

ways in they coach their children to perceive and think about their own emotions, have been related to the ways their children learned to think about their internal experiences – a particularly salient finding for father-child relationships. This highlighted the importance of paternal acceptance of their children's feelings.

Child outcomes may have been positive in the midst of parental affective illness if proper emotion socialization was taught. Focht-Birkerts and Beardslee (2000) attempted to incorporate affect into a risk and resilience model, suggesting that children have thrived when affect was tolerated and accepted in a family, but may have been at risk when affect was restricted within a family. Through three case vignettes, the researchers examined family processes through the theory of psychoanalysts Stolorow and Atwood (as cited in Focht-Birkerts & Beardslee, 2000) that children of depressed parents have tended to remain silent about their emotions so that they can accommodate their overwhelmed parents. This accommodation may have led to a family environment where children have withdrawn emotionally as a result of their parents' vulnerability. In response, parents have believed they were harming their children and attempted to shield the children from themselves, which distanced the family members from each other. Thus, parental encouragement of their children to share their emotional experiences and validation of their children's feelings was essential if children were to adjust normally in the midst of these adverse circumstances. Affective attunement has been crucial to ending a cycle of distance perpetuated by depressed parents and their children (Stolorow & Atwood, as cited in Focht-Birkerts & Beardslee, 2000).

Three families, each containing at least one parent suffering from depression, participated in a qualitative research study by Focht-Birkerts and Beardslee (2000)

examining patterns and tendencies of such families. Background information was collected, and a family intervention was held. The intervention consisted of calculating risk and resiliency, and subsequently meeting together as a family to gain education about affective illness and discuss experiences regarding living in a family with an affectively ill parent. The family participated in follow-up interviews to share information post-study. Throughout the process, formal protocols and open-ended interviews were used to assess participants' behavior and attitude changes occurring as a result of participation throughout the study (Focht-Birkerts & Beardslee, 2000). Of the three vignettes outlined by Focht-Birkerts and Beardslee (2000), only one family included a depressed father. In this vignette, along with the two others, children were initially reluctant to discuss their parents' problems. However, parental permission to voice emotions and experiences, along with cognitive and emotional development through adolescence, appeared to contribute to healing.

The research on parental effects on child emotionality has been quite clear that parents, especially fathers, have played a significant role in the way their children have experienced and thought about emotions. Fathers' encouragement for their children to be brave reduced children's externalizing symptoms in a unique way, while mothers' encouragement for their children to be brave did not have the same effect (Dittman et al., 2011). The research also found that parents' acceptance of children's emotions, and encouragement for their children to share their emotions openly, were connected to children's acceptance of their own emotions and willingness to share them (Focht-Birkerts & Beardslee, 2000; Hunter et al., 2011). Clinically, it is important to help fathers

learn to accept and encourage emotional openness to promote child well-being, which may present challenges when fathers are depressed.

Relationship quality. ***Parental hostility.*** Men who are depressed have tended to exhibit symptoms that manifest as anger (Cochran & Rabinowitz, 2003) and irritability (Chuick et al., 2009). Reeb, Conger, and Wu (2010) conducted a quantitative examination of paternal depressive symptoms and hostility as related to their adolescents' functioning. This study intended to examine adolescent gender as a potential variable, as well as paternal hostility as a moderator for adolescent functioning and paternal depression. Findings indicated that gender, in addition to adolescent perception of fathers' hostility, was a moderator for the transmission of depression through generations. Adolescent girls who perceived their depressed fathers as highly hostile were at a higher risk for depression than adolescent boys. The father-child relationship, as experienced by the adolescent, played a significant role in the development of depression.

Parental distance and lack of warmth. A large body of research has addressed the relationship between parental levels of warmth and closeness and the impact on developmental outcomes of their children. This has been a significant area of interest when studying the effects of parental depression. Related to the findings revealed by Reeb et al. (2010), a study by Kane and Garber (2008) revealed that parental depression tended to have the greatest effect on children when children perceived significant interpersonal conflict with these parents. Additionally, Angst et al. (2002) reported that while depressed women tended to exhibit tearfulness and emotional disturbance, depressed men tended to use coping methods that typically involve avoidance of

problems, such as substance abuse. Men also tended to engage in hobbies as a way to cope with their depression.

In a longitudinal, quantitative study, Reeb and Conger (2009) examined the relationship between adolescent gender, paternal depressive symptoms, and adolescent perception of father-adolescent closeness. Results showed that adolescent girls were more vulnerable than adolescent boys to their fathers' depressive symptoms, especially when the adolescents perceived low levels of father-adolescent closeness. This was true even after controlling for maternal depressive symptoms, previous depressive symptoms of the adolescents, and family demographic information. These results were similar to those of the study by Elgar et al. (2007), which listed parental nurturance and rejection as predictive of child outcomes, showing that low levels of nurturance and high levels of rejection from depressed parents had significant effects on children.

Brown, McBride, Shin, and Bost (2007) were interested in identifying parenting predictors of children's attachment security with their fathers, such as fathers' involvement and parenting quality. Forty-six two-to-three-year-old children and their fathers participated in this study. Participants were found non-randomly through day care centers and via printed fliers posted in various community locations. More than half of participants were European American (71% of fathers and 58% of children), and the study reports that the next most common ethnicities, in descending order, were Asian American, Latino American, African American, and South American (percentages were not reported). More than half of participating families had combined incomes of over $60,000 (57.9% of families). Attachment security was defined using John Bowlby's definition (as cited in Brown et al., 2007) of a child's confidence in a caregiver, as

exhibited by the desire for contact with the caregiver and use of the caregiver as a safe, stable factor on which to rely in the environment. Attachment security was assessed using the Attachment Behavior Q-set. Qualitative methods were used to assess parenting quality (i.e., self-report, interviews and observations of father-child play sessions in a laboratory). Positive dimensions of fathering quality included in the study were supportive presence (e.g., warmth and emotional support), limit setting and structure, effective and age-appropriate instruction of children, positive regard, personal enjoyment and fun (experiencing pleasure during interactions), and cooperation toward shared goals. Negative dimensions of fathering quality included hostility, intrusion/denial of children's autonomy, and disengagement and distance from children (both physically and psychologically). Research assistants then coded these dimensions using a seven-point scale (Brown et al., 2007).

Results were obtained by first conducting bivariate correlations and regression analyses to examine the direct effects of father involvement and fathers' parenting quality on father-child attachment security, and then conducting a series of regression analyses to examine interaction between father involvement and fathers' parenting quality (Brown et al., 2007). Findings indicated that positive parenting behaviors, or high-quality parenting behaviors in fathers, were related to more secure father-child attachment relationships, regardless of the level of father involvement. However, fathers that exhibited low parenting quality tended to have less secure attachment relationships when father involvement was high. That is, while father involvement was not significant as a predictor of child attachment to fathers who displayed positive and appropriate parenting,

father involvement acted as a detriment to child secure attachment when fathers engaged in low-quality parenting behaviors (Brown et al., 2007).

Schenck et al. (2009) studied the relationship between adolescent mental health problems and mattering to step- or non-residential fathers. *Mattering*, in the context of this article, is to be needed by another, to be someone of whom another is concerned, or to generally be noticed by another, regardless of the emotional tone of a relationship or interaction (Schenck et al., 2009). Adolescent participants completed a seven-item self-report scale on the amount they believed they mattered to their mother, stepfather, and nonresidential father. Scale items were answered on a five-point scale (from “1 = strongly agree” to “5 = strongly disagree”). The questionnaire was developed specifically for this study. Results showed that mattering to both step- and non-residential fathers was correlated with adolescent mental health problems. Mattering to both types of fathers was directly related to adolescent reports of internalizing problems. There was an interaction between type of father (either stepfather or nonresidential father) and adolescent externalizing problems according to teacher reports. Adolescent externalizing problems were related to high levels of mattering to one type of father when levels of mattering to the other type of father were low. Because the method for assessing mattering was an adolescent self-report scale, results may not have accurately reflected objective relational information, and may instead be more reflective of adolescents’ perception of mattering to parents. Other variables should be considered when interpreting results, such as adolescent mental health history, family history, and self-esteem. For example, a stepfather may have put forth great effort to show that the adolescent mattered to him, and the adolescent may have been resistant to accepting the stepfathers’ attempts at

relationship for various reasons. Parents' reports of how much their adolescents matter to them would have been an important factor to examine as well, to include both perspectives of a two-way relationship.

Celano et al. (2008) studied the relationship between depressive symptoms in caregivers, parenting behaviors, and family processes to identify areas of parenting that may be associated with depression in caregivers. All participants in this study were from low-income, urban, African American families who had children with chronic asthma. Families were asked to complete three tasks, including a task with content of loss (e.g., discussing what the child perceived as the "saddest thing that ever happened" [Celano et al., 2008, p. 13] to him or her), a conflict-inducing task (e.g., discussing and attempting to resolve a topic over which the caregiver and child typically argue) and a task that encouraged cohesion (e.g., listing favorable attributes about each other and about their family). Interactions were coded on prevalence of specific positive and negative parenting behaviors. It was discovered that as depressive symptoms increased in caregivers, caregivers exhibited less warmth and more hostility toward children when faced with the more emotionally arousing tasks relating to loss and conflict (Celano et al., 2008).

George et al. (2006) conducted another study examining the connection between the family environment and child maladjustment. The researchers studied the interaction between three types of child psychopathology (i.e., conduct problems, depression, and inattention/hyperactivity), and factors related to the family environment (i.e., types of interactions, community, and family structure). Also taken into consideration were SES, age, and general psychopathology. Four hundred and fifty-three first grade through fourth

grade students and their families were selected using a stratified sample to represent the community population. Children were separated into groups of problem children (n = 309) and non-problem children (n = 144). Seventy-nine percent of children were male, and 95% were European American. The sample was predominantly middle-class, but all SES levels were represented in the sample.

Results of the study revealed that depression and conduct problems, but not inattention/hyperactivity, were predictive of impairments in family functioning (George et al., 2006). Several factors of family functioning were predictive of having a child with depression, including impaired family relationships (i.e., low family cohesion, little expressiveness, low levels of independence, elevated levels of conflict and control at home), and family insularity (i.e., low levels of recreation and intellectual/cultural pursuits). Families who had a child with conduct problems tended to have low cohesion, low levels of intellectual/cultural pursuits, and elevated levels of family conflict (George et al., 2006).

Negative family environments have included factors such as emotional/ psychological distance, conflict, hostility, and low levels of cohesion, warmth, support, and positive contact with the community (Brown et al., 2007; Celano et al., 2008; George et al., 2006; Schenck et al., 2009). Another aspect of the overall family environment involves the family members' attributions of one another. Studies by Slatcher and Trentacosta (2011) and Sheeber et al. (2009) examined the associations between parents' attributions of their children's behaviors and child outcomes.

Slatcher and Trentacosta (2011) were interested in discovering the connection between depressive symptoms in parents and child behaviors and emotional language.

Thirty-five families, each with two parents and a three-year-old to five-year-old child, participated. Participants were found through day-care centers and on craigslist.com. Demographic information included 79% European American participation, 21% Latino American participation, 4% African American participation, and 2% participation by other ethnicities. Each child in the study was told to wear a “special magic shirt” (Slatcher & Trentacosta, 2011, p. 445) with a pocket decorated with colorful cartoon characters. The pocket contained a small recorder (Electronically Activated Recorder; EAR) that could record for up to 19 hours; the EAR’s placement within the pocket “allow[ed] the EAR to be ‘out of sight, out of mind’” (Slatcher & Trentacosta, 2011, p. 445). Transcriptions from the EAR were sent to a linguistic analysis program to count frequency of negative-emotion words, and child behaviors (e.g., crying, whining, arguing) were also coded. The same procedure was conducted with the same families one year later. Results of this study indicated that display of depressive symptoms in either parent was associated with an increase in child crying or displaying anger (Slatcher & Trentacosta, 2011). When either parent was depressed during the first examination, child use of negative emotion word use tended to increase during the examination the following year. These findings were most significant among families who reported higher levels of parent-child conflict and parents who fight more frequently with their children (Slatcher & Trentacosta, 2011).

In order to directly examine parents’ attributions of their children, Sheeber et al. (2009) conducted a study that looked at parents of depressed, sub-diagnostic, and non-depressed adolescents. The researchers were interested in whether differences in parents’ attributions of adolescents’ behaviors would emerge based on children’s symptoms, and

whether parenting behavior would change with these attributions (Sheeber et al., 2009). Seventy-six girls, 48 boys, and their families were videotaped trying to solve a problem in a naturalistic setting. Parents' behaviors, adolescents' behaviors, and attributions of the adolescents' behaviors were observed. Sheeber et al. (2009) found that parents who attributed their adolescents' negative behavior during interactions to the adolescent (i.e., blaming the adolescent for negative behavior or viewing it as intentional) tended to also use harsher, more aggressive parenting techniques than did parents who did not make negative attributions to the adolescents. This was true of both mothers and fathers. Additionally, parents of depressed adolescents tended to make more negative attributions to the adolescents' behaviors (Sheeber et al., 2009).

Child outcomes have been related not only to parenting practices, but the quality of the relationship as well (Sheeber et al., 2009; Slatcher & Trentacosta, 2011). The amount of warmth and engagement that parents have displayed in their parent-child relationships may have fostered very positive outcomes in children. This has posed difficulty when looking at the influence of depression on fathers' relational patterns – if depressed men tend to display avoidance, withdrawal and irritability, it may be difficult for them to engage with patience and warmth with their children.

Family Process

Family system and relational dynamics. Families are complicated systems that involve patterns of interaction and structures that organize those interactions. Minuchin (1974) developed a cohesive model of *structural family therapy* that helps identify patterns and structure within family systems, which is comprised of boundaries, hierarchy, and subsystems. Boundaries define the level and nature of family participation by

individuals, and may range from rigid (excessively firm boundaries that may contribute to cold, distant, or *disengaged* relationships) to diffuse (loose boundaries that may contribute to inappropriately close or *enmeshed* relationships). Ideally, boundaries should be clear, to allow for closeness and sharing among family members as well as appropriate distance to clearly define a family member's function and relationship with other members (Minuchin, 1974). *Hierarchy* refers to the family rules of authority and responsibility, and subsystems refer to smaller groups within the family system. For example, the *parental subsystem* refers to the parents as a unit. Hierarchy may differ slightly between cultural groups, but adults should be on the top of the hierarchy and children should be under them. Problems may arise when children move up in the family hierarchy or when one parent or both parents move down on the hierarchy. Minuchin (1974) also discussed *triangulation*, which occurs when three family members are engaged in an interactional pattern that is dysfunctional. An example of triangulation is a situation in which a child is caught between two parents in conflict who are each attempting to persuade the child to take his or her side (Minuchin, 1974).

Franck and Buehler (2007) developed a systemic model to interpret interactions between two parents and an adolescent, focusing specifically on adolescent perception of triangulation and the protective effect of parental warmth. Data was collected using videotaped interactions and semi-structured interview methods. Two hundred and five boys, 211 girls and their families participated; 91% of participants were European American, with a median household income of $70,000. Most parents reported that they had completed some college.

According to the results of the study, the risk of adolescent intrapersonal distress became elevated when parents violated boundaries by bringing the adolescent into a triangulated interaction (Franck & Buehler, 2007). Adolescent internalizing problems may have occurred if the triangulation was solidified and became more frequent during interactions within the family system. Findings also indicated that depressive affect in both mothers and fathers, regardless of the depressive affect of their spouses, contributed to conflict and impaired marital functioning. Families in which both parents experienced depressive symptoms were at a heightened risk for impaired family functioning. This study also found that parental warmth toward adolescents, as rated by observers' perceptions, did not serve a significant protective function (Franck & Buehler, 2007).

Cummings, Keller, and Davies (2005) were interested in building upon previous research to develop a family process model that would incorporate aspects of paternal depressive symptoms into a conceptualization of family functioning. Two hundred thirty-five participating families with children in kindergarten were recruited through schools and various community locations, with specific intent to target low-SES and culturally diverse areas. The sample was representative of the population of the mid-size Midwestern town and large New England city being studied. Families were only eligible to participate if they had been living together for longer than three years. Data were collected using questionnaires and observational methods. Cummings et al. (2005) found that depression in either parent was correlated with marital problems, child maladjustment, and parenting deficits, though marital conflict and parent and child gender appeared to mediate the relationship between parents' depressive symptoms and child outcomes. Boys' prosocial behaviors were negatively correlated with paternal

depressive symptoms, while girls' peer exclusion was more strongly associated with depressive symptoms in mothers (Cummings et al., 2005).

Shelton and Harold (2008) were also interested in studying parental depressive symptoms and child outcomes, with specific focus on parents' relationship insecurity, conflict between parents, and parenting behaviors. Participants (352 children ages 11-13 along with their parents and teachers) were residents of the United Kingdom who had participated in a three-wave longitudinal study from 1999-2001 studying children's everyday life and development. The researchers stated that the sample was representative of the population, though only children living in two-parent families were included in the study (87.2% lived with biological parents, 11.1% lived with a mother and stepfather, and 1.7% lived with a father and stepmother). Parents, teachers, and children were asked to fill out questionnaires and assessment measures inquiring about everyday life, demographics, economic information, family relationships, and psychological health (Shelton & Harold, 2008).

Results of Shelton and Harold's (2008) study provided information about the effects of depressive symptoms and relationship insecurity on marital relations and child psychological functioning. Depressive symptoms and relationship insecurity were directly correlated with marital conflict one year later. There was a correlation between fathers' rejection of children in the midst of inter-parental conflict and child internalizing problems, and a correlation of mothers' rejection during times of inter-parental conflict and child externalizing problems. This study supported the view that the pathway between parental depression and child outcomes is through functioning of the parent-child relationship during times of marital conflict (Shelton & Harold, 2008).

Schacht, Cummings, and Davies (2009) conducted a similar study focusing specifically on the function of fathers within the family context. Two hundred fifteen families, each with at least one child in kindergarten, participated in a three-wave study. Participants were not randomly selected and were paid for participation. Ethnic identities of participants were similar to U.S. Census Bureau data from 2000 (Schacht et al., 2009). Self-report measures were used to assess parents' marital conflict, parenting skills, and psychological functioning. Parent-report measures were used to assess children's emotional security and adjustment.

Schacht et al. (2009) hypothesized that paternal depressive symptoms and alcohol consumption would lead to maladaptive behaviors within the marital relationship, in turn affecting child adjustment, with childhood emotional security acting as a mediator. Two hundred thirty-five families, who had been living together for at least three years and had a child enrolled in kindergarten, participated at the beginning of the study, and 215 families remained throughout the study. Participants were recruited through flyers, postcards and referrals in South Bend, Indiana and Rochester, New York and surrounding cities. The majority of couples (88.1%) were married and had been living together for an average of 11 years. Participants were 79.2% European American, 15.3% African American, 3.8% Latino American, and .4% biracial. Families were asked to visit the lab twice a year for three years; fathers were asked to attend the first visit each year, but not to attend the second visit. Parents were given the Conflict and Problem Solving scale to assess parents' behavior during times of marital conflict, and the Alabama Parenting Questionnaire and the Parental Acceptance-Rejection Questionnaire to assess parenting behaviors. Paternal depressive symptoms were assessed using the Center for

Epidemiological Studies Depression Scale (CES-D) self-report measure. Alcohol use was assessed using the Parental Alcohol Experiences self-report scale. Children's emotional security was measured using the Security in the Interparental Subsystems Scale, a parent-report measure. Children's adjustment was measured using the CBCL during each interval of the longitudinal study (Schacht et al., 2009).

Results of this study indicated that fathers' alcohol consumption during the first phase of the study was predictive of higher levels of marital conflict during the second phase of the study (Schacht et al. 2009). Additionally, increased marital conflict was correlated with lower levels of positive parenting behaviors by fathers. Decreased positive fathering then predicted increased externalizing behaviors in children. Paternal depressive symptoms during the first phase of the study predicted internalizing problems in children during the third phase of the study. Children's emotional security intervened as a protective factor in the relationship between fathers' influence and child adjustment; children with less emotional security presented with more internalizing and externalizing problems (Schacht et al., 2009).

Questions have begun to arise in research involving the nature of the marital relationship and its connection with spousal depressive symptoms. The direction of the relationship may provide insight into intervention strategies in families with a depressed parent or spouse. Expanding on previous research by others (Rehman, Gollan, & Mortimer, as cited in Beam et al., 2011; Proulx, Helms, & Buehler, as cited in Beam et al., 2011; Whisman, as cited in Beam et al., 2011), Beam et al. (2011) examined the depression-marital discord relationship by teasing out specific aspects of the correlation, using twins as participants. The researchers posed possibilities such as heritability of

depression, *active gene-environment correlation* (the process of seeking out situations that reflect already-present genetic characteristics), *evocative gene-environment correlation* (the process of eliciting negative responses from one's spouse, thus diminishing the quality of the marital relationship), and *environmental selection* (extraneous variables in the environment, such as poverty, causing both increase in depressive symptoms and marital discord). Beam et al. (2011) cited three studies (South & Krueger; Spott, Neiderhiser, et al.; Spotts, Pedersen, et al.) that indicated that a genetic component plays a role in mediating the correlation between depressive symptoms and marital quality. Beam et al. (2011) hypothesized that selection correlations would be responsible for a part of the marital quality-depressive symptoms correlation, and that the impact of marital quality on depressive symptoms would be greatest for mothers. They expected the impact of low-quality marriages on depressive symptoms to be smaller for fathers and non-mothers.

Beam et al. (2011) acquired a sample of 1,566 pairs of twins with children (1,007 monozygotic and 560 dizygotic) from the Australian Twin Registry from 1988-1989. Participants were married, in a relationship and living together, or married but separated. The article stated that because a large majority of the population was European American, no data on racial or ethnic background was collected. Mean age for participants was 41.52. Twins' current depressive symptoms were self-reported on eight items of the Delusions-Symptoms-States Inventory. Marital quality was also self-reported using likert-scale responses to three items that typically characterize positive marital interactions. Parenthood status was also obtained: full-time parent or non-full-time parent (participants with adult children over 18 years old were considered to be non-full-time

parents). Beam et al. (2011) used descriptive statistics and multivariate analyses to analyze their data. Results showed that even when confounding variables were controlled, level of marital support is a significant predictor of depressive symptoms, suggesting a reciprocal relationship regardless of genetic effects. One-way directionality was not found. Genetic selection effects were found to affect women but not men, though marital support's prediction of depressive symptoms did not vary between husbands and wives. The marital support-depressive symptom relationship was also found to be stronger for full-time parents than non-full-time parents (Beam et al., 2011).

Lim, Wood, Miller, and Simmens (2011) examined the connection between paternal depression and child outcomes, with a focus on the relational pathways to dysfunction. Lim et al. (2011) looked at family psychological and physical symptoms in two parent families. They hypothesized that negative family processes would be correlated with physical and psychological symptoms in children, and that the effects of parental depression would vary by parent gender and presence of interparental negativity. The study included 106 participating families with children ages 7-17 (67 boys and 39 girls). Fifty percent of participants were African American, 32% were European American, 10% were Latino American, and 8% identified as "other." The Beck Depression Inventory-II assessed parental depressive symptoms, the Children's Depression Inventory measured children's depressive symptoms, the State-Trait Anxiety Inventory for Children measured anxiety symptoms, the Family Process Assessment Protocol assessed and quantified interparental behaviors (e.g., hostility, warmth) and parenting behaviors (e.g., hostility, intrusiveness, neglect, warmth, child-focus, and responsiveness), and Asthma disease activity was assessed using medical tests of

pulmonary functioning along with symptom presence. Lim et al. (2011) inquired about medication adherence via telephone before each office visit. Results showed support for their hypothesis that negativity in the family environment was correlated with child internalizing symptoms, and child-internalizing symptoms were predictive of asthma disease activity. There was also a direct correlation between parental depressive symptoms and parents' behavior toward each other and their children (Lim et al., 2011).

The studies described above show the potential impact of paternal depression on family dynamics and child outcomes. Particularly, the level of prosocial behaviors in boys was connected to depressive symptoms in their fathers (Cummings et al., 2005). Cummings et al. (2005) also found a correlation between depression and marital problems, while Schacht et al. (2009) found a negative correlation between marital conflict and fathers' positive parenting behavior. As marital conflict increased, fathers found it more difficult to utilize positive parenting. Negativity within a family system has been related to child internalizing symptoms, and child-internalizing symptoms were found to be predictive of health problems (Lim et al., 2011). Depression in fathers, if left untreated, has developed into more serious, system-wide problems within the family.

Conflict resolution. Poor conflict resolution has been a focus of study as a negative contributor to the family process. Marchand and Hock (2000) tested the hypothesis that depressive symptoms in both husbands and wives would be negatively correlated with marital satisfaction and positively correlated with conflict resolution strategies that involved attacking the other. Forty European American married couples in the non-clinical population completed questionnaires with Likert scales to measure depression, marital satisfaction, and conflict resolution styles. They found that conflict

resolution style was predicted in both genders by marital satisfaction and depressive symptoms. Attacking conflict-resolution strategies in husbands was only predicted by husbands' level of marital satisfaction, but attacking conflict-resolution strategies in wives was predicted by wives' level of marital satisfaction as well as depressive symptoms. Husbands' depressive symptoms accounted for 15% of the variance in avoidance conflict-resolution strategies.

A similar study by Marchand and Hock (2003) expanded their examination of family conflict strategies to focus on their connection to child outcomes. They predicted that attacking and avoidance conflict strategies would relate differently with child internalizing and externalizing symptoms, and studied family dynamics (e.g. parental attributes) as mediating variables. Participants were six-year-old European American children (28 girls and 23 boys) and their families. Parents completed questionnaires assessing depressive symptoms, marital conflict resolution techniques, and child behaviors. Teachers also completed questionnaires on child behavior. Results showed that mothers and fathers reporting depressive symptoms also reported more conflict resolution strategies involving avoidance and attacking (Marchand & Hock, 2003). In addition, parents who utilized avoidance strategies tended to have children who exhibited more internalizing behaviors, with internalizing behaviors increasing when both parents utilized avoidance strategies (Marchand & Hock, 2003).

A study by Du Rocher Schudlich, Papp, and Cummings (2004) addressed the differences between conflict resolution styles in husbands and wives with dysphoria, with focus on both positive and negative conflict resolution styles. *Dysphoria* was defined as subclinical levels of depressive mood symptoms. The researchers expected that level of

dysphoria would be positively correlated with negative conflict strategies, and negatively correlated with positive conflict strategies. They also expected that spouses' dysphoria would predict communication patterns, and that dysphoria would correlate more strongly with negative conflict behaviors in minor arguments than in more significant arguments. Finally, they expected that the predictability of dysphoria on communication would vary by gender (Du Rocher Schudlich et al., 2004).

Two hundred sixty-seven couples in the South Bend, Indiana area, recruited via media sources (newspaper, television radio, postcards and fliers), referrals, and public schools participated in the study (Du Rocher Schudlich et al, 2004). Couples qualified if they had been living together for at least two years and had a child between the ages of eight and 16. Ninety-seven percent of couples were married, with an average marriage length of 13 years. Forty-four percent of wives and 37% of husbands had a college degree or higher. Ninety-one percent of couples were European American, 7% African American, and 2% identified as biracial or Other. Dysphoria was measured with the CES-D, a 20-item scale that measures depressive symptoms, and the Depression subscale of the SCL-90-R, which is a 13-item scale that assesses depressive symptoms. Twenty-two percent of husbands and 35% of wives in this study reached a cutoff score that may indicate serious depression. Questionnaires, as well as laboratory observations of couples' interactions during topics of major and minor disagreement, were used to collect data. Observers coded tactics used by couples during disagreements. Researchers used the Marital Daily Records protocol to code tactics, emotional display, and level of conflict resolution on a scale from 0-9. Parents were told that their child would watch the recording of the minor disagreement at a later time (Du Rocher Schudlich et al., 2004).

Results of the study indicated that dysphoria was more strongly correlated with negative tactics in conflict resolution and negative emotionality in men than in women, after controlling for marital satisfaction and dysphoria in partners (Du Rocher Schudlich, et al., 2004). Specifically, dysphoric men displayed low levels of positive conflict strategies and high levels of maladaptive strategies (defensiveness, withdrawal, hostility, insults). Dysphoric men also displayed high levels of anger and sadness during conflict. These results did not vary significantly by disagreement type; they tended to engage in similar tactics whether the disagreement was major or minor, even though they were aware that their child would watch the minor disagreement (Du Rocher Schudlich et al., 2004).

When men have experienced depression, their conflict resolution styles may have included low levels of constructive problem solving. Men who reported depressive symptoms tended to report using strategies during conflict of avoidance and attacking (Marchand & Hock, 2003), which was not surprising, given the withdrawal and irritability typically displayed in men with depression. Du Rocher Schudlich et al. (2004) found similar results, and showed increases of negative conflict resolution strategies as well as decreases in positive conflict resolution strategies in men with dysphoria. Another significant finding of this study was that men with dysphoria presented with heightened anger and sadness during conflict. Addressing problem-solving and conflict resolution strategies in men with depression may play a role in emotional and interpersonal improvement.

Father involvement as a moderator for maternal depression. Chuick et al. (2009) noted that men with depressive symptoms tended to use withdrawal and avoidance

as coping strategies for their depression, indicating that involvement in families may have been diminished. Research has surfaced showing the moderating effect that father involvement has had on the well-established negative effect of maternal depression. Mezulis, Hyde, and Clark (2004) were interested in the long-term effects of father involvement on child outcomes. Three hundred fifty women over the age of 18 and their husbands/partners participated throughout the course of a longitudinal study. Participants were recruited through medical clinics in 1990-1991. Women qualified if they were 12-21 weeks pregnant at the beginning of the study, were not disabled, were living with the father of the baby, were not students, were not currently searching for employment, and spoke and read English sufficiently to complete phone interviews and written questionnaires. Another requirement is that either the mother or the father must be working for pay. Fifty-six percent of mothers had a college degree, 28% reported some post-high school education, 14% had a high school degree, and under 2% reported no high school degree. Ninety-three percent of mothers were European American, 2.6% African American, 1.9% Native American, 1.8% Latino American, and less than 1% Asian American. The median family income was $45,000. Mothers and fathers were interviewed initially in their homes, and then were asked to mail in questionnaires one, four, and 12 months after the birth of the baby. Additionally, questionnaires were to be filled out and phone interviews completed when the children were in kindergarten, and the children's kindergarten teachers completed questionnaires as well. Questionnaires measured maternal and paternal depression, father involvement, fathers' parenting styles, and behavioral problems in children. Hierarchical multiple regressions were used to analyze data (Mezulis et al., 2004).

Mezulis et al. (2004) found that the amount of time fathers spent with their infants moderated the effect of parental depression on child internalizing behaviors. When depressed fathers spent a great deal of time with their children, the effect of parental depression was heightened and predicted higher levels of child internalizing behavior. The absence of depression in fathers did not diminish the effects of maternal depression on child outcomes. Regarding parenting styles of fathers, children with fathers who exhibited warmth tended to have fewer internalizing behaviors than children with fathers who exhibited less warmth. However, when children had depressed mothers, the strong negative correlation between paternal warmth and child internalizing behaviors only existed when fathers spent small amounts of time with children. Children displayed the highest level of internalizing behaviors when their mothers were depressed and their fathers reported high levels of warmth and moderate amounts of time spent with children (Mezulis et al., 2004).

A study by Culp, Schadle, Robinson, and Culp (2000) set out to examine the connection between father involvement and children's self-competence and behavioral issues. They expected that as father involvement increased, parent reports of child internalizing and externalizing problems would decrease. Participants were first-born kindergarteners and first graders (10 girls and 15 boys) from intact families in which both parents were employed. Children were either the only child in their family or had one sibling. All parents had jobs in which they worked 30 or more hours per week. Participants were recruited through flyers in public schools and after-school programs in a Midwest town and surrounding suburbs. The average age of mothers and fathers were 35.6 years and 37.4 years, respectively, and the average time that couples had been

married was 10.7 years. Two of the participating parents (one woman and one man) identified as Native American, while the remaining parents identified as European American. Participating families were of middle- to upper-middle-class. Parents independently completed the CBCL to measure child behavior problems, and completed the Parental Involvement and Child Care Index. Fathers filled out the Parental Involvement and Child Care Index as it applied to their own involvement with their children, and mothers completed it as it applied to their husband's involvement with their children.

The results of this study showed a negative correlation between father involvement and mothers' reports of child externalizing problems, such as aggression (Culp et al., 2000). Contrary to the expectations of the researchers, mothers' perceptions of father involvement were positively correlated with mothers' perceptions of child internalizing problems. That is, the more mothers perceived fathers to be involved, the higher mothers rated child internalizing problems. A positive correlation between father involvement and child experience of paternal acceptance was found. There was no significant relationship found between father involvement and children's competencies in cognition, physical activity, and peer acceptance. However, it was important to note several significant limitations of this study, which were acknowledged by the researchers. First, the sample size of 25 was small, which the researchers attributed to strict inclusion criteria. Conclusions must be drawn with caution when using such a small sample size. Second, the demographic information showed very little diversity, as most participating parents were middle-class European American professionals with a college education who worked full time or nearly full time. Parents were generally in their mid-30s. This

sample was not representative of the general population in the United States, and excluded families from varying socioeconomic statuses, years of education, and racial or ethnic group. Average age of parents, number of siblings, and other variables may also differ when other diversity criteria are met.

Field, Hossain, and Malphurs (1999) also examined fathers' interactions with their infants, with emphasis on family patterns of interaction. The researchers used a sample of 80 families with healthy infants (3-6 months old) that were determined to be of low socioeconomic status by the Hollingshead Index. Fifty-six percent were African American, 38% were Latino American, and 6% were European American. The mean ages of fathers and mothers were 23 and 20, respectively. Fathers had an average of 10 years of education and mothers had an average of 11 years of education. Ninety six percent of parents were living together, though none of the parents were married. Eighty two percent of mothers and 21% of fathers were unemployed. Couples had been in a relationship for an average of 2.8 years. Mothers were the primary caregivers in 98% of participating families (Field et al., 1999).

Mothers and fathers were asked to complete questionnaires about sociodemographic variables and depression (Field et al., 1999). Parents engaged in play with their infants individually for three minutes, and the interactions were videotaped. Parent gender in order of interactions was counterbalanced, to rule out interaction order as a confounding variable. In the interactions, an infant was put in an infant seat on a table, while a parent was facing the infant in a chair. Parents were instructed to engage with the infant in a way similar to how they would interact with the infant at home. Videotaped interactions were scored for two domains using three-point Likert scales for

10 items on each domain: the infant's state (i.e. behavior and presentation) and parental behavior (Field et al., 1999).

Field et al. (1999) found that, compared with depressed mothers, depressed fathers displayed more physical activity, verbalizations, and facial expressions, and the overall interaction behavior scores were higher. Depressed fathers also displayed less intrusiveness and withdrawal, and more positive parenting than depressed mothers. Infants of depressed fathers scored more favorably on several items, including head orientation, fussiness, gaze, state, facial expression, and vocalizations. Even when infants had two depressed parents, infants showed the same favorable scores during interactions with their fathers as infants who had only one depressed parent. Another important finding was that infants with depressed fathers and non-depressed mothers showed higher scores on head orientation and vocalizations when interacting with their fathers than with their mothers, and the non-depressed mothers themselves scored lower than their depressed male partners on several domains as well. In other words, depression in fathers was correlated with lower levels of optimal interactions between their non-depressed female partners and their infants (Field et al., 1999).

Low and Stocker (2005) studied the connection between depressed mood in parents, marital hostility, and child outcomes. The study included 136 children (80 boys, 56 girls; mean age = 10 years and two months) and their families. Families were required to be intact to participate in the study. Eighty percent were European American, 13% Latino American, 3% African American, and 4% Asian American or Other (Low & Stocker, 2005). Families were instructed to attend a two-hour laboratory visit, during which they were to play a game together, discuss activities that they liked to do together,

and discuss a topic of disagreement or conflict within the family. Coding systems for marital conflict, parent-child hostility, and children's adjustment were used to operationalize data collected during the laboratory visits. Parents completed questionnaires addressing their marriage and their children's adjustment, and filled out the BDI to assess depression. Children were interviewed about their own adjustment and relationships within the family. Data were analyzed using path analysis. Multiple path models were tested for the relationship between depressed mood, marital hostility, and child adjustment (Low & Stocker, 2005).

Results showed that fathers' depressed mood was directly associated with child externalizing behaviors (Low & Stocker, 2005). Children's adjustment was indirectly correlated with depressed mood in fathers, with parent-child hostility as a mediator. Parent-child hostility also acted as a mediator in the relationship between children's adjustment and parental marital hostility. The research also found that maternal depressed mood was only associated with child adjustment through its relationship with marital hostility, a finding that the researchers describe as unexpected (Low & Stocker, 2005).

A similar study by Weinfield, Ingerski, and Moreau (2009) attempted to discern the additive and interactive effects of parental depressive symptoms and child adjustment. 49 families with toddlers (30 months old) participated in the study. All but one family were described as intact. Eighty-two percent of toddlers were European American, eight percent were African American, six percent were multiracial, two percent identified as Other, and two percent did not disclose ethnicity; median household income was $65,000 per year. Parents completed self-report measures of depressive symptoms, quality of their marriage, and behavior problems in their children. Parents received "modest" (Weinfield

et al., 2009, p. 41) compensation for their participation. Data were analyzed by first using descriptive statistics on the variables, and then examining direct relationships between parent gender and toddler internalizing and externalizing behavior, using simple regression analysis. Then, multiple regression analysis was used to study the additive effects of parental depression on child behavior. Lastly, Weinfield et al. (2009) tested an interactive, rather than additive, model of parental depressive symptoms was tested using hierarchical multiple regression analysis.

This study found that maternal depressive symptoms and paternal depressive symptoms were both significant predictors of externalizing behavior in toddlers (Weinfield et al., 2009). This study also showed support for an additive model of prediction of externalizing behavior in toddlers, but not for an interactive model. That is, mothers and fathers with depressive symptoms had distinct contributions to toddlers' behaviors. The researchers found that maternal perception of marital quality affected the magnitude of the relationship between depressive symptoms and child adjustment. However, paternal perception of marital quality did not significantly predict depressive symptoms or child adjustment (Weinfield et al., 2009).

These studies echoed results that depression in fathers have had implications for their children, and child externalizing behavior has been no exception (Culp et al., 2000; Low & Stocker, 2005). An important finding came from the study by Field et al. (1999), which showed that fathers' depression affected the parent-child interactions between non-depressed mothers and their children. However, it also clearly illuminated the hope for men with depression and their families.

An important factor to consider when reporting research has been demographic diversity. Several of the studies utilized to show effects of fathering on family dynamics used samples of primarily middle-class European Americans. While these studies yielded valuable results, it is crucial to remember that research using relatively uniform middle-class samples was inherently limited. Evans (2004) conducted a meta-analysis of a wide variety of studies showing the negative implications of poverty in childhood. These included higher levels of difficulty and disruption in the psychosocial environment (e.g., violence, separation, interaction with aggressive peers, placement in foster care, negative and punitive parenting strategies, less social support, fewer resources, less cognitive and verbal stimulation) and physical environment (e.g., higher likelihood of living near physically toxic locations and exposure to cigarette smoke indoors, more noise in schools, more crowded schools, more crowded living environments, higher neighborhood crime rates). These factors may have affected the results of studies that focused on or included significant samples of low-income families.

Fathers' and children's cognitive and language development. A growing significant body of research has begun to address the connection between fathering and child cognitive development, describing the benefits of positive, healthy fathering. The association has been well documented in a variety of ways. For example, in a Canadian study, Pougnet, Serbin, Stack, and Schwartzman (2011) found that child nonverbal cognitive functioning in middle childhood was related to fathers' positive involvement. Pancsofar, Vernon-Feagans, and the Family Life Project Investigators (2010) cited research by Pancsofar and Vernon-Feagans (2006), showing that when fathers used a variety of words when interacting with their 24-month-old children, the children's

development of expressive language was more advanced at 36 months than children whose fathers did not use a variety of different words during interactions.

Shannon, Tamis-LeMonda, Lodon and Cabrera (2002) conducted a study addressing fathering as related to child cognitive development, with the specific intention of examining fathers' sensitivity and child responsiveness and competence, in addition to fathers' behaviors and demographics and their relationship with child outcomes. Participating families were found through local community centers in a large city. The sample included 65 fathers (ages 18-46) and their children (31 girls and 34 boys ages 23-30 months). Sixty-three percent of fathers were Latino American, 29.2% were African American, 4.6% were Asian American, and 4.6% were European American. Twelve fathers spoke Spanish, two fathers spoke Mandarin, and the rest spoke English. Forty-three and one-tenth percent of the fathers completed under 12 years of high school, 32.3% of fathers received their GED or high school diploma, and 24.6% completed some college or received a college degree. All participating families had low-income households and were eligible to receive government aid. Eighty-four and two-thirds percent of fathers worked full-time or part-time. Seventy-two and one-third percent of mothers in participating families were not employed.

Shannon et al. (2002) conducted home visits with mothers and children initially, and children were given the mental scale of the Bayley Scales of Infant Development, 2nd Edition (BSID-II). Soon after, they conducted home visits with fathers and children, in which fathers were interviewed and then videotaped during interactions with their children. Interactions were scored with the Caregiver-Child Affect, Responsiveness, and Engagement Scale, which used Likert-scales to measure frequencies of specific

interactions. This study used descriptive statistics and factor analyses of the behaviors of fathers and children to analyze data, as well as multiple regression analyses to determine specific father and child contributions to the development of children and logistic regressions for children who showed delays. The analyses revealed two general characteristics in father: *Responsive-Didactic* (attunement to children, responsiveness, positivity, education) and *Negative-Intrusive* (excessive structure, negativity, intrusiveness, achievement-directedness). Children were also found to have three specific interactional patterns as well, including *Playful-Communicative* (positivity, play and involvement with toys, and advanced language), *Social* (attunement, positivity, and responsiveness) and *Regulated* (persistence with tasks and emotional self-regulation; Shannon et al., 2002). The Responsive-Didactic characteristics used by fathers were positively correlated with children's Playful-Communicative and Social behaviors. Children's scores on the mental scale of the BSID-II were predicted by fathers' relational behaviors. Children who scored in the normal range on this scale were significantly more likely to have father-child relationships characterized by warmth, communication and playful behaviors than were children who showed delays on the mental scale of the BSID-II (Shannon et al., 2002). A significant strength of this study was the demographic diversity of the sample. It is important to note that these findings were not necessarily directional, so it would be inaccurate to state that fathers' positive behaviors caused more optimal development in children. However, these findings provided information about the nature of father-child relationships in children who were cognitively well developed.

Cabrera, Shannon, and Tamis-LeMonda (2007) obtained data from the National Early Head Start Research and Evaluation Project and the Early Head Start Father Study

to examine three aspects of father engagement, including description of engagement, personal characteristics of fathers in relation to engagement, and effects of engagement on child outcomes (i.e., cognitive, verbal, emotional, and social). A sample of 290 families with two- and three-year-old children and 313 families with children in pre-K was included in this study. All participating families included a biological, resident father. This article reported that 60% of participants were European American, and the other participating families were African American and Latino American. Assessment measures were demographic questionnaires, child development questionnaires (BSID-II and Peabody-Picture Vocabulary Test-III for all children, and Woodcock Johnson Applied Problems and Letter-Word Identification and Leiter-Revised Examiner Rating Scale for preschoolers), and videotaped interactions between fathers and their children, in which fathers were asked to play with specific toys with their children (Cabrera et al., 2007).

The study's first finding was that fathers' education and income significantly predicted child outcomes (Cabrera et al., 2007). Second, child cognitive and language development, along with social and emotional development, were positively associated with supportive parenting at two and three years old. Fathers' supportiveness at pre-K did not have a significant effect on child outcomes. Third, for children in pre-K, fathers' intrusive parenting is negatively correlated with child cognitive and language development. Paternal intrusiveness was related to child emotional regulation at two years old, but not at three and pre-K (Cabrera et al., 2007).

Pancsofar et al. (2010) studied the specific aspects of fathering that may contribute to children's language development. They used data from the Family Life

Project (FLP; Vernon-Feagans et al., as cited in Pancsofar et al., 2010). Participants were 1,292 infants and their families from low-income rural counties, about half of whom were below the poverty level. Over the course of three years, researchers conducted seven home visits, during which parents were asked to engage infants by reading a wordless picture book to the infants as they normally would. Microphones were attached to the parents' clothing. Research staff members conducted home visits, and were assigned to participating families based on matching ethnicity and geographical location. Participating families completed questionnaires about demographics, child characteristics, parent education and language, and child communication (verbal and nonverbal). Researchers conducted hierarchical linear regression analyses to analyze data. Pancsofar at al. (2010) found that even after controlling for demographic information, fathers who were better educated and used a more expansive vocabulary during the reading of the picture book had infants with better communication skills at 15 months and more advanced development of language at 36 months. Some research has found that maternal use of various word types and lexical diversity has contributed to child language development (Pan, Rowe, Singer, & Snow, 2005; Weizman & Snow, 2001), but no connection was found between maternal language use and child language development in this study (Pancsofar et al., 2010). Though this study was conducted in a laboratory setting, one of its strengths was its departure from traditional parent-reported activity and its use of videotaped observations for analysis.

The type and quality of parenting behavior used by fathers has had an important connection with child cognitive and language development. When father-child relationships involve warmth, communication and play, children were likely to show

healthy development (Shannon et al., 2002). Cabrera et al. (2007) found similar results showing the benefits of supportive parenting and the consequences of parental intrusion on child cognitive and language development. Fathers appeared to have an impact on their children's course of development, especially during early childhood.

Domestic Violence and Depressed Fathers

Substance abuse and depression. There has been a complex, intertwined relationship between active substance use disorders and mood or anxiety disorders. Grant et al. (2006) introduced their study by noting that an individual experiencing intoxication or withdrawal from substances may present with anxiety or mood symptoms, and it can be challenging to separate one disorder from another. Their survey, the National Institute on Alcohol Abuse and Alcoholism's National Epidemiologic Survey on Alcohol and Related Conditions, involved 43,094 participants interviewed face-to-face to examine the comorbidity of several specific mood and anxiety disorders with substance use disorders. Grant et al. (2006) found that anxiety and mood disorders, including depressive disorders, were strongly correlated with substance use disorders. About 20% of participants with a substance use disorder also experienced one or more mood episodes within 12 months. Approximately 20% of those suffering from a substance use disorder had a comorbid mood disorder. Similarly, approximately 20% of those with a mood disorder also had a comorbid substance use disorder (Grant et al., 2006).

Research connecting alcohol abuse with depression (Angst et al., 2002; Chuick et al., 2009; Grant et al., 2006) has been of concern in light of a study by Greenfield, Venner, Kelly, Slaymaker, & Bryan (2012), in which researchers examined the correlation between Major Depressive Disorder and substance abuse treatment efficacy in

emerging adults. Greenfield et al. (2012) studied *abstinence self-efficacy (ASE),* which has been defined as “the confidence to abstain from using alcohol or drugs in different situations” (p. 247), and which has tended to predict treatment outcomes quite accurately. Study participants with Major Depressive Disorder reported lower ASE than participants were did not have Major Depressive Disorder. This was true specifically when situations involved negative affect. Although participants who reported depressive symptoms over the past week showed increases of ASE during their treatment, their ASE levels remained lower than non-depressed participants (Greenfield et al., 2012).

It has been difficult to tease out substance abuse problems from emotional disturbance or psychiatric illness, which has made treatment complicated. Unfortunately, the high likelihood of comorbid substance abuse problems and depression has indicated a need for treatment of both conditions. Individuals with substance abuse disorders who also have depressive disorders may face additional challenges that their non-depressed counterparts may not face. Greenfield et al.’s (2012) study showed that depressed patients in substance abuse treatment were less confident in their ability to exercise self-control to maintain sobriety compared to those who were not depressed. This has highlighted the importance of treatment of depression in conjunction with substance abuse treatment when an individual is depressed.

Substance abuse and domestic violence. If there has been support for a connection between substance abuse and depression, it has been important within this area of study to look at the potential effects of substance abuse within the family context. Research has also been conducted to examine the link between substance abuse and domestic violence, and has highlighted the danger of domestic violence that accompanies

substance abuse. It should be noted that while there has been extensive attention given to male perpetrators and female victims of domestic violence, this aggression was not exclusively committed in this pattern. Males may have been victims of domestic violence as well, and the implications are serious (Hines, Brown, & Dunning, 2007).

Fals-Stewart (2003) studied male-perpetrated violence against female partners in order to determine specific mechanisms at work between substance abuse and alcohol. Couples, both perpetrators and victims, participated in this study. Couples were interviewed periodically face-to-face and were asked to keep daily logs of male alcohol consumption (i.e., quantity consumed and length of time using alcohol) and physical aggression (i.e., specific type, ranging in severity). Participants were recruited from domestic violence programs and alcohol treatment programs. It was found that male-to-female physical aggression was eight times more likely to occur during the days when men had consumed alcohol than on days when men had not consumed alcohol. Additionally, the likelihood of physical aggression that was classified as “severe” was 11 times higher on days when men drank compared to days when men did not drink. Even more striking was the finding that when men had been drinking heavily, their likelihood of male-to-female physical aggression and “severe” physical aggression were 18 and 19 times higher, respectively (Fals-Stewart, 2003). Though the link between male substance abuse behavior and intimate partner violence is clear, it is important to note that substance abuse behavior in female victims may be a salient factor as well. Cunradi, Caetano, and Schafer (2002) found that female alcohol problems and drug use were both risk factors for moderate and severe intimate partner violence by male perpetrators.

An English study by Rolfe et al. (2006) studied the relationship between alcohol and aggression and other associated variables in a sample of 403 untreated abusers of alcohol (295 male and 108 female). The study found that among the participating individuals, there were 200 reported incidents of violence. The perpetrators reported that they had consumed an average of 20 units of alcohol during the incident of violence (one unit of alcohol in the UK is equivalent to slightly more than one half of a drink in the US). Qualitative interviews revealed that these heavy drinkers were aware that there was a relationship between alcohol, violence, and aggression. Participants also discussed cultural aspects of masculinity as significant in violence after drinking. In qualitative interviews, many participants referred to a male's confidence and bravado increasing while under the influence of alcohol (Rolfe et al., 2006).

Substance abuse and domestic violence have been interrelated and difficult to identify as separate problems within an individual. Bennett (2008) reviewed literature on this topic and found that for individuals who were addicted to substances and perpetrate domestic violence, participation in substance abuse treatment alone lowered the likelihood of engagement in domestic violence behaviors. Level of motivation and stages of change were also discussed in Bennett's (2008) review. Because a large number of domestic violence perpetrators have been required by the court to attend treatment and were not attending by choice, they may not have had a positive and motivated attitude toward changing their behavior. This can be problematic, as intervention programs may approach each participant as if they are all in the same stage of readiness for change. Though many programs have been unable to provide individualized approaches due to funding and resources, clients may have benefited when motivational strategies and

engagement methods, including culturally sensitive interventions, were included in substance abuse and domestic violence treatment (Bennett, 2008). Lastly, Bennett (2008) cited relevant literature to emphasize the importance of assessment throughout the treatment process, rather than just during the intake phase. Professionals should have sufficient education about substance abuse and domestic violence, and should have specific steps in place regarding how to proceed if client needs change.

Shorey, Febres, Brasfield, and Stuart (2012) were interested in self-reported Axis I psychopathology among men who were arrested for intimate partner violence. The researchers focused specifically on depression, PTSD, substance abuse disorders, and anxiety disorders (Generalized Anxiety Disorder, panic disorder, and social phobia), and wanted to find out if there was a difference in severity between men meeting cutoff scores for diagnosis of these disorders and men who did not meet the cutoff. The study included 308 men who were referred to violence intervention programs by the court. The average age was 33.1 years old, and the average annual income was $34,465. Seventy-one and one-fifth percent were European American, 12.6% were African American, 8.1% were Latino American, 2.3% were American Indian/Alaskan Native, 1.3% were Asian American/Pacific Islander, and 3.9% other. 28% of men were married, 29.8% were cohabiting, 19.7% were dating, 12% were single, 6.1% were separated, and 3.9% were divorced. The men's current relationships had lasted an average of 6.2 years. Participants were given questionnaires assessing intimate partner violence, mental health, and social desirability (i.e. the participant's ability to respond to others in a socially appropriate way).

Shorey et al. (2012) found that perpetration of intimate partner violence was positively correlated with depression, along with Post-Traumatic Stress Disorder, substance abuse disorders, Generalized Anxiety Disorder, and social phobia. In this sample, alcohol use disorders were more prevalent than the other disorders examined in the study. These findings were significant given the research showing the correlation between alcohol use disorders and depression (Angst et al., 2002). Readers should also be reminded of the unique expression of male-type depression and depressed men's reluctance to seek help (Addis & Mahalik, 2003). This study utilized self-report measures, which may have underestimated the prevalence of depression in this context. In light of the study's limitations, it shed light on the prevalence of mental health disturbance within this population.

The documented connection between caregiver substance abuse and child maltreatment has been perhaps even more concerning than the aforementioned research. Parental substance abuse has been one of the top reasons for involvement of child protective services within families (Tuten, Jones, Schaeffer, & Stitzer, 2012). *Child protective services* (CPS) are government-run, local systems that are in place to help protect children from various forms of maltreatment. Tuten et al. (2012) reviewed the literature and found significant disadvantages of children with caregivers who abuse substances. Compared with children whose parents did not abuse substances, children with substance abusing parents were more likely to be abused by the parent more than one time, to be placed in foster care, and to spend more time outside of the home once they are removed from their parents' care. The parental rights of substance abusing

parents were more likely to be terminated than those of parents who had their children removed for reasons not related to substance abuse (Tuten et al., 2012).

Laslett, Room, Dietze, and Ferris (2012) sought to examine this relationship utilizing data from 29,455 children who were the subjects of substantiated child abuse or neglect cases in the Victoria Child Protection Data System from 2001-2005 in Australia. Twenty-three percent of the children had two or more substantiated reports, while the remaining children only had one substantiated report. The study found a significant relationship between caregiver alcohol abuse and recurrent instances of child maltreatment. There was a comparably significant but independent relationship between recurrent instances of child maltreatment and caregiver abuse of substances other than alcohol as well (Laslett et al., 2012).

A similar study by Besinger, Garland, Litrownik, and Landsverk (1999) examined the case records of 639 children ages 0-17 removed from their homes by CPS and placed in foster care for a minimum of five months. Reasons for removal included substantiated sexual abuse (13%), physical abuse (22%), emotional abuse (11%), neglect (61%), and caregiver absence (42%). The researchers compiled and examined the children's CPS, police, and court records, as well as medical and psychiatric information. They also collected information on caregiver substance abuse, which they defined as problematic use of alcohol and/or other drugs. Caregiver substance abuse was determined using case files (for example, if a caregiver was mandated to attend a substance abuse program), CPS report of caregiver substance abuse, or *Diagnostic and Statistical Manual of Mental Disorders* [3rd ed., rev.; APA, 1987] diagnosis of Substance Abuse or Dependence. Findings showed that a shocking 79% of the cases studied involved caregiver substance

abuse. Children whose caregivers had problems with substance abuse were more likely to be removed due to neglect, and less likely to be removed for sexual abuse or physical abuse. Caregivers with substance abuse problems also tended to have their children removed for the first time at younger ages than caregivers without evidence of substance abuse problems (Besinger et al., 1999).

The relationships between depression, substance abuse, and domestic violence have had serious consequences for individuals and families. Research in the previous section showed a connection between depression and substance abuse problems (Grant et al., 2006), and it has been shown that depression also has a direct, positive correlation with intimate partner violence (Fals-Stewart, 2003; Shorey et al., 2012). While there are several possibilities for reasons for this connection, it is clear that action must be taken to address mental health issues in the treatment of men who perpetrate intimate partner violence. Requiring even more urgent action is the connection between parental substance abuse and child maltreatment (Besinger et al., 1999; Laslett et al., 2012; Tuten et al., 2012). Parents who have perpetrated violence against their children need help to address substance abuse and mental health problems in addition to targeting the child maltreatment itself.

Cultural Considerations

In this section, cultural components of the concept of masculinity were outlined, as well as expectations and the role of the father in the family context. It was crucial to the goal of this doctoral project to incorporate a description of the diversity in expectations and perceptions of the role of males across various cultures. It was important to note that the study of depression in men of color and/or minority status is relatively

new and not yet comprehensive. However, without a clear understanding of these components, this project would fail to address one of the most salient factors about a man and how he operates within social and family environments.

It was also important to note that the purpose of this section was not to give readers a thorough understanding of all cultural groups, nor to comprehensively examine the nuances of each group. The objective of the following section was to provide readers with general information about the values, traditions and clinical issues of specific cultural groups in order to more accurately inform the research that has been outlined in previous sections. The current section consists of generalizations that do not apply to all members of the cultural groups described, and must be interpreted with caution. In order to understand an individual's family and individual experience, a thorough, comprehensive, and sensitive exploration of the makeup of the client's cultural identity must be done within the therapeutic context.

Bronfenbrenner (1977) developed a systemic theory to explain the growth of people throughout their lives, explaining the immediate, personal, external, and broad systems that affect development and identity. According to Bronfenbrenner's theory, an individual's environment has consisted of a microsystem, a mesosystem, an exosystem, and a macrosystem. A *microsystem* was an interaction between a person and his or her immediate environment (for example, a child in school). A *mesosystem* was the connection and relationship between significant settings. An example of a mesosystem might be the interaction between an individual's school and his or her family. An *exosystem* involved the social structures in which a person engages, but the structures of an exosystem have typically been broader and more generalized than those of a

mesosystem. An exosystem may include neighborhoods, government agencies, and social networks. A *macrosystem* was defined as cultural or subcultural patterns or ideals that manifest in microsystems, mesosystems, and exosystems. Macrosystems have instilled motivation and purpose to the actions, roles, and structures of the three other types of system. For example, interactions between cultural values and generally accepted priorities have been considered macrosystems. This theory of systemic functioning should be applied within the therapeutic context to examine all personal, cultural, and familial forces that may be impacting a client's identity and functioning.

African American fathers. The public has had a tendency to perceive African American fathers as absent, and this has presented a unique struggle for African American fathers who have been present and fulfilling personal and familial obligations responsibly (Oren & Oren, 2010). One of the primary struggles of African American men has been to show that they have been present in their families and responsible in their roles as fathers. When they have been unemployed, they have been at risk for being less responsible and less engaged with their families. They have felt a heavy responsibility to be a provider for the family, and this has exacted a toll when they have been unable to contribute the way they wished to contribute. Unemployment can also have evoked public assumptions about their character and work ethic that may have been quite untrue. Another factor that has posed risk to the involvement of engaged African American fathers in their families has been the perception that their parenting efforts have gone unseen by the public, due to the cultural stereotype that African American fathers have been under-involved or absent from their children's lives (Oren & Oren, 2010). The intense effort that many African American fathers have exerted into asserting their

responsible parent role could have led to burnout or contributing less to the family over time. However, one of the protective factors for African American men has been support from their families. When they have received this support, they have enjoyed higher self-esteem and better quality of life (Bowman, as cited in Oren & Oren, 2010).

It has been important for African American fathers to examine their own childhoods to understand their perceptions of fatherhood and of their own competency, and identify potential areas of psychological difficulty (Toldson & Toldson, as cited in Oren & Oren, 2010). Though many African American fathers have fallen somewhere in the middle of the continuum, there has been a distinction between African American fathers who grew up with absent fathers and no role models, and those who grew up with the positive influence of a number of African American male role models. Roberts-Douglass and Curtis-Boles (2013) examined the process of African American masculine identity formation with a qualitative study of 15 African American men between the ages of 18 and 22, and found significant diversity among experiences and perceptions. An interesting finding was that participants had been exposed to specific representations of African American males, including “tough guys,” “gangsters/thugs,” “players of women,” “flashy/flamboyant,” “athletes,” “providers,” and “role models.” Family was a significant factor in the development of masculine identity. Many of the participants reported feeling pressured to adhere to traditional masculine expectations, such as aggression, appearance of toughness, disengagement at school, focus on physical appearance, and athleticism, and expressed that failure to meet these expectations would invite humiliation and hostility from peers (Roberts-Douglass & Curtis-Boles, 2013).

Seven of the 15 participants in the study by Roberts-Douglass and Curtis-Boles (2013) cited male teachers as having a significant influence on their perception of masculinity. These participants reported observing these teachers' behaviors and gleaning important information from them. They learned from these teachers that men should exhibit responsibility and accountability, self-respect and respect for others, self-control, and implementation of moral values, as well as possess the skills to solve problems and use communication to resolve conflict.

John Head (2004) beautifully and painfully illustrated the manifestation of emotional content in his Black male role models in this excerpt:

> The black men who were my role models when I was growing up bore whatever hardship life handed them with quiet dignity. They didn't complain. They didn't even talk about their troubles. Church was the only place I ever saw anything resembling an outpouring of emotion by these men. When they were 'shouting' or 'had the Holy Ghost,' they might perform a kind of stomping dance and flail about so violently that church ushers had to restrain them to keep them from hurting themselves or other congregants. But the most striking thing to me was to see the emotional outbursts that erupted from these stoic men. They would cry out, often detailing the miseries they had suffered and thanking God for allowing them to hold up under this burden. The men often had tears streaming down their faces. This is a deeply spiritual experience, but I believe it also is psychologically therapeutic, allowing black men to release pent-up emotions in a culturally acceptable way. But I knew even as a child that outside the church any display involving the shedding of tears would be considered unmanly. (pp. 36-37)

This highlighted the power that cultural expectations carry in regard to ethnicity and gender. It reflected cultural norms of what is acceptable and what is unacceptable in the environment in which he was raised. It was also an introduction to issues concerning depressed males in the African American community. Sinkewicz and Lee (2011) found that the risk of African American men developing a major depressive episode has been one and a half times higher if they were fathers, though higher education (completing some college) appeared to offset the risk. Additionally, they found that comorbid disorders, such as anxiety, substance issues, and medical conditions, were prevalent among African American fathers with depression (Sinkewicz & Lee, 2011). These findings have provided significant reasons to give clinical attention to African American fathers with depression.

Two salient factors in the study of depression in African American men were the effects of racism and the taboo of suicide. Racism may have played a significant part in the onset and severity of depression (Head, 2004). The effects of racism and the presence of depression have both included a strong sense of hopelessness. When struggling against racism, African American men may have felt they were exerting tremendous effort to maintain that hope in the face of racism, and the onset of depression may have caused them to relinquish any hope onto which they may have been holding. Additionally, mental health services may not have been easily accessible to African American men, partly due to their skepticism regarding the medical system (Head, 2004). However, with the increasing rate of suicide among African American men, access to mental health services has become crucial. Head (2004) identified the obstacles to open communication about suicide in the black community. First, there was a religious component: the

religious community has generally believed that suicide causes a person to go to hell. Second, the oppression that African American men have faced throughout history has required a strong will and intense desire to survive. When a African American man has ended his life, he has essentially insulted his own community, showing disrespect for all that they have endured (Head, 2004). Experiencing hopelessness in a community to which hope has been critical can lead an individual to hide their experience from others, rather than share what needs to be shared in order to heal (Head, 2004).

Asian American fathers. The construct of masculinity in the Asian American culture can involve a struggle between traditional and Americanized identities. Traditionally, Asian men have held the responsibility of making family decisions, and their wives have supported their position as the authority of the household (Kramer, Kwong, Lee, & Chung, 2002). They have also been expected to show loyalty and honor to the elderly. Adults have often cared for their aging parents and invited them to live in their homes, though this has varied by specific cultural background (Kramer et al., 2002). These traditional values have differed from the individualistic nature of American culture, and this may have created conflict.

Liu and Iwamoto (2006) conducted a study to examine gender role conflict in Asian American men as a consequence of a number of variables, including self-esteem, psychological distress, and cultural values. They found that among Asian American men, those who adhered to traditional Asian cultural values experienced higher levels of gender role conflict than those who did not. Also, gender role conflict was predicted more strongly by traditional Asian cultural values than by racial identity (Liu & Iwamoto, 2006). Sun and Starosta (2006) interviewed Asian American professionals and

discovered that most had experienced invisibility, or a downplaying of their racial background. The traditional male gender role as the visible authority and decision-maker, against the experience of invisibility among Asian American men, may have made for a difficult contrast in identity formation.

Immigration has been a significant factor to consider when working with Asian American men. Iwamoto and Liu (2009) outlined a brief history of Asian immigration, which included exploitation of Asian men in the American work force during the 1800s and early 1900s, and assignments to work in jobs typically assigned to women. While the numbers of Asian immigrants grew, the phenomenon of the *model minority* began to emerge. The majority population pointed towards Asian Americans' tendency to work hard and avoid conflict as the model for others. Hostility between Asian immigrants and immigrants of other ethnicities increased, and contributed to an assumption that Asian Americans were free of social and economic stressors (Iwamoto & Liu, 2009). This was not so. Asian Americans may have struggled to maintain their previous socioeconomic status upon immigration due to various obstacles, including lack of fluency in the English language, limited opportunities for employment, and classification as a member of a minority group (Oren & Oren, 2010). Takeuchi et al. (2007) studied the connection between immigration factors and mental illness, and found intriguing results. Among a variety of factors related to immigration such as time since immigration, age at immigration, English proficiency and nativity status, English proficiency had the strongest correlation with psychiatric disorders specifically in men, including depression (Takeuchi et al., 2007). Additionally, Kim, Gonzalez, Stroh and Wang (2006) studied cultural marginalization in Korean American, Chinese American, and Japanese American

parents and their adolescents, and found that marginalization was correlated with depressive symptomatology.

Acculturation and fatherhood in Asian American families has presented a challenging dynamic between men and their children. Oren and Oren (2010) outlined descriptions of traditional Asian fatherhood in many Asian cultures, such as keeping distance between themselves and their children, instilling values of obedience and respect, and maintaining the financial stability of the family. A father's fulfillment of these expectations and raise successful children has been viewed as being directly connected with his own ability as a father. Strictness of fathers toward their children has been common, as this approach has been seen as helpful in guiding children toward desirable outcomes. Younger generations of Asian Americans that have aligned more strongly with American culture may not have looked favorably upon this fathering approach, and may have instead felt controlled and restricted (Oren & Oren, 2010). Some Asian American children may have preferred open expression of affection and dialogue about decisions to the traditional structure, and may have felt rejected by their fathers who used more traditional parenting methods. However, they may also have felt a great deal of respect for their fathers for their commitment to their families (Oren & Oren, 2010).

Dinh and Nguyen (2006) studied the relationship between the parent-child acculturative gap as perceived by both parents and children, and parent-child relationships. The researchers noted that while there has been diversity among Asian subgroups, traditional values of patriarchy and distinction among family roles have tended to be quite similar. One hundred and seventy-two college students from a large Northwest university and their parents (identifying as Chinese, Vietnamese, Filipino,

Korean, and other Asians) participated in the study. The mean age of immigration among college students was nine years old, with an average of 11 years in the U.S. Eighty-two percent of mothers and 80% of fathers were not born in the U.S. Participants were given various questionnaires to assess self-perception of acculturation and quality of parent-child relationships. Results showed that the magnitude of the acculturative gap was significantly correlated with family functioning. Children who perceived their parents to be excessively traditional, or who thought their parents perceived them as excessively Americanized, reported lower-quality relationships with their parents than those who did not perceive a large acculturative gap. While acculturative gap was significant in predicting parent-child relationship for both mothers and fathers, fathers' level of acculturation was a more significant element of the parent-child relationship than mothers' level of acculturation (Dinh & Nguyen, 2006).

Oren and Oren (2010) reviewed the literature and highlighted several helpful strategies for working with Asian American fathers. First, selecting an appropriate match between the client and therapist has been key in quelling the client's anxiety and promoting the therapeutic relationship. Asian American men's perception of their therapist may have been tied to age, gender, education and life experience, and they may generally prefer older male therapists. Second, the impact of immigration should be considered and explored. Third, dignity has been an important construct for Asian American men, and attempts to maintain their dignity throughout the therapeutic process should be emphasized. Many Asian American men have felt shame and guilt over failure to fulfill family roles and expectations leading them to seek help, so therapists should take care to convey their respect to these clients and reframe their help-seeking behavior

as a strength. Fourth, therapists should work carefully with emotions and recognize cultural reasons that Asian American men may have chosen to conceal emotions. Fifth, it has been important to identify strengths in a culturally appropriate way. For example, therapists should avoid language that may make expressions of strengths sound like boasting, and focus on strengths within relational and familial contexts rather than personal assets. Sixth, therapists should explore the construct of masculinity with Asian American male clients, and help them work through cultural conflicts that arise surrounding masculinity. Seventh, there should be a focus with Asian American fathers on the impact of cultural orientation on their relationship with their children. For more traditional fathers with less traditional children, conflicts and misunderstanding of one another may have occurred. Eighth, working within a systems framework may be the most helpful strategy, given the focus on interdependence within Asian American families. Therapists should familiarize themselves with the family structure and hierarchy and focus on the family's values.

Latino American fathers. A diverse group of ethnic backgrounds have comprised the Latino American, or Hispanic, population. Latino Americans' nationalities have included Mexico (63%), Spain (1.3%), Puerto Rico (9.2%), Cuba (3.5%), Dominican Republic (2.8%) and other Central American (7.9%) and South American (5.5%) countries (Ennis, Rios-Vargas, & Albert, 2011). As has been typically true for Asian Americans, Latino Americans' complex immigration histories have played a significant role in individuals' identities and clinical issues.

In a review of the literature, Halgunseth, Ispa, & Rudy (2006) identified three main parental goals that help to organize the family system within the Latino American

community: familismo, respeto, and educacion. All three terms refer to the interdependence that has been highly valued in Latino American families. The term *familismo* has been used to describe the strong loyalty and commitment that individuals have been expected to have for their families, and the assumption that family needs supersede individual needs. *Respeto* has been reflective of relational harmony within the family, and has been achieved through respect for others as well as self-respect. This has included teaching children politeness and respect for elders, and awareness of one's own role in the family in order to behave accordingly. *Educacion* has referred not only to academic education, but also training in abstract concepts such as morality and personal responsibility. A person may exhibit educacion through warmth toward others, good manners, acknowledgement of their familial role, respect, responsibility, and honesty (Halgunseth et al., 2006).

Latino American masculinity has derived much of its definition from the rather abstract term *machismo*, which may have had both positive and negative connotations. Fragoso & Kashubeck (2000) identified a number of definitions from different authors to describe this term. On the more antisocial side, machismo has referred to a sense of arrogance, aggression and callousness within relationships, and may have included a positive view of violence as power. A more prosocial description of machismo has included a responsibility to protect others who are helpless, a sense of physical strength, dignity, sexual attractiveness, and courage. Fragoso and Kashubeck (2000) conducted a study to examine connections between the concept of machism*o*, mental health (defined as depression and stress), and gender role conflict. One hundred and thirteen Mexican American men completed questionnaires measuring machismo, gender role conflict,

acculturation, depression, and stress. Results showed that as machismo and gender role conflict (i.e., restricted emotionality) increased, depression and stress also increased. Fragoso and Kashubeck (2000) found that endorsing a rigid view of masculine gender role that has been aligned with traditional Mexican American values and experiencing gender role conflict has been predictive of self-reported depression and stress. However, machismo alone was not connected with gender role conflict. Another finding of this study was that acculturation and stress were negatively correlated (Fragoso & Kashubeck, 2000).

Culturally supported parenting styles and acculturation levels must be examined when working with Latino American families in order to understand family functioning and implications for child adjustment. Parke et al. (2004) studied the relationship between economic hardship, parenting, acculturation, and child adjustment in Mexican American and European American families. Participants were 167 Mexican American children and 111 European American children, all in the fifth grade, and their families. Their first finding was that per capita income was a more salient factor in economic pressure for European American families than Mexican American families, though economic pressure was significantly correlated with depressed mood in men and women of both groups. Both Mexican American and European American families showed a correlation between marital problems and child outcomes, and a correlation between hostile parenting by the father and child outcomes. For Mexican American families, family structure was impacted by level of acculturation. When mothers were more acculturated, marital conflict increased, but hostile parenting strategies decreased in both mothers and fathers. For both groups, children experienced negative adjustment when faced with parental

marital problems, regardless of changes in parenting strategies. This finding was particularly salient in Mexican American families.

Cultural identity has been comprised of many complex factors, including externally and internally defined identities, social identities, personal identities, and the integration of several identities into a single individual (Chen, 2009). A person's ethnicity, country of origin, immigration status and cultural identity have not defined his or her whole self, but rather were significant components of the self that have provided a starting point for exploring the world of a client or family entering treatment. Within-group differences have been vast, and the significance of one identity (race or gender, for example) may have been more salient for one individual than it was for another. It is important not only to examine the externally defined culture of a client, but the personality and internal world as well.

Summary

Depression in men has been somewhat neglected, because many of the symptoms that depressed men have experience and displayed were often symptoms other than sadness, including fatigue, restlessness, sleep difficulties, irritability, feelings of emptiness, antagonistic behaviors, anger, use of distractions, excessive time spent working, maladaptive coping skills, and avoidance of emotional content. The risk of suicide for men has been shown to be alarmingly high – women have been more likely to think about suicide and make attempts, but men have been much more likely to complete suicide. Though there have been different theories about gender-sensitive conceptualization of male depression, it has become clear that cultural and societal norms exert much influence on men's expression of negative emotions, with pressure put on

men not to show sadness or weakness. Men, regardless of age and cultural background, have been less likely to seek professional help. In fact, depressed males seeking reassurance were actually be more likely to experience rejection. There was a strong correlation between shame and depression, and men may have experienced shame in conjunction with perceived weakness.

Depressed parents were at a heightened risk for engaging in negative parenting practices, as they more frequently showed hostility, intrusiveness, neglect, and low levels of warmth and involvement than non-depressed parents. When families were less cohesive, less involved in activities (cultural, intellectual, and recreational), and engaged in more conflict, child maladjustment was more likely to occur. However, depression in parents may not have been the specific problem, but rather the type of parenting used. Parenting practices served as a mediator between parental depression and child maladjustment, with parental nurturance of their children promoting positive child outcomes regardless of parental depression. Positivity suppression was more common in families with a depressed father than in families with a depressed mother and those in which neither parent is depressed. Child outcomes were positively associated with fathers allowing and encouraging their children to express their emotions, validating their experiences, and helping them solve problems effectively.

Family relational dynamics were related to depressive symptoms as well. Marital discord has occurred in when one partner is depressed, and the parent-child relationship in the midst of marital conflict was an important in facilitating positive child outcomes. Level of marital satisfaction, in turn, was predictive of conflict resolution. Additionally, when fathers were depressed, they tended to use avoidance and attacking conflict

resolution styles in their families. Positive father involvement and warmth during early childhood was positively correlated with child cognitive and language development.

Comorbid substance abuse disorders have occurred commonly in those with mood disorders, and symptoms of intoxication and withdrawal may appear similar to symptoms of a mood disorder. For these reasons, it has been difficult to tease apart substance abuse and depression, but it has been important to consider substance abuse as a possible variable in the treatment of depression. The consequences of substance abuse were serious, including increased risk for intimate partner violence and child maltreatment.

Cultural factors were important to consider in the treatment of depression. The concepts of masculinity, strength, and success varied by cultural group, and it would have been impossible to cover every cultural group in this literature review. Three prevalent groups, African American fathers, Asian American fathers, and Latino fathers, were briefly covered in order to provide basic information as a starting point with which to begin exploring cultural identity in relation to depression in men. Themes of family of origin, history of immigration and oppression, and cultural norms of manhood emerged as important facets for men in these cultural groups. However, therapists should remember that each client has had his own story, experiences, beliefs, and personality, so it has been recommended to take an approach to treatment that includes exploration of these factors in addition to cultural background.

CHAPTER III

Methodology

This chapter contains five sections: review of the literature, field consultation, presentation production, presentation delivery, and evaluation of the presentation by recipients.

Literature Review

The literature review was developed through the use of several sources, including articles retrieved through research databases, census information received through websites, and various books. Books that were utilized in this literature review explored topics relevant to the subject of the literature review, such as men and masculinity, male depression, and cultural components of masculinity and depression. EBSCOhost, PsychINFO, and Google Scholar were utilized to obtain electronic versions of research articles. Many research articles cited in the literature review were obtained directly through the journals that published them, when articles were not available through the databases. The Google search engine was used to obtain factual information, such as relevant statistics documented by census results. References cited by the aforementioned articles and books were also used to locate other articles that appeared relevant to the topic of the literature review.

Field Consultation

Interviews were conducted with three field consultants who possessed knowledge and professional experience relevant to the topic of the project. The consultants were asked to discuss the culture of masculinity today and their clinical experience with men's

issues, as well as their experience with depression in men. They were authors and clinicians who possess Master's and Doctorate degrees, and were willing to discuss their experience and knowledge about this topic.

Selection and interview of field consultants. The field consultants were found through professional websites and networking with other professionals and academic instructors. Electronic email and telephone calls were used to contact potential consultants. Consultants were given information about the doctoral project, the role of the field consultant, methods of conducting consultation, and a list of interview questions that would be asked during the consultation. Those who agreed to participation in field consultation for this project were asked to provide written consent affirming their awareness and understanding of their role as a field consultant (see Appendix A). Interviews were conducted in person, in each field consultant's office. This project addressed both the male population and depressed individuals, and focused on the intersection of those populations. The field consultants chosen have experience in the areas of men's issues as well as an understanding of cultural issues involved in men's issues and depression.

Characteristics of field consultants. The following professionals were contacted and informed about the content of the project, and agreed to participate voluntarily in the project. Chen Z. Oren, Ph.D. was a clinical psychologist who specializes in men's issues. Dr. Oren has written many articles on issues related to counseling and therapy with men. He also co-edited the book Counseling Fathers, which outlines the strengths and challenges of fathers of various demographics and cultural backgrounds relevant to clinical work. At the time of this writing, Dr. Oren served on the board of the American

Psychological Association's Society for the Psychological Study of Men and Masculinity, and was actively involved in the organization of events highlighting issues specific to men and fathers.

Evelyn Kohan, Ph.D., clinical psychologist, was a graduate of the California School of Professional Psychology and worked with adult individuals and couples in private practice for over 25 years. She was experienced in graduate instruction and clinical supervision. Among an array of specialties, Dr. Kohan had a specific primary interest in men's issues. She has been passionate about identifying the biopsychosocial differences between men and women, and helping her male clients and those around them to value their strength and integrity. She has taken a collaborative approach with her clients to equip them with tools and strategies to handle life stressors.

Dr. Elaine Burke is a clinical psychologist who has worked with men in therapy for many years in a variety of clinical settings. She has worked with them in both inpatient and outpatient mental health settings, (including a number of years with veterans), as well as with men who have neurological or health concerns. In her work with children, she has worked with some men who wanted to work on issues related to being a father and obtaining a balance between family life and individual interests. Dr. Burke has also done research and has clinical interests related to men in the areas of racism, diversity training, gender roles, health beliefs and behaviors, the impact of having a disability, and in the area of trauma (as related to ethnic/racial identity or acculturation level).

Doctoral Project Presentation

Presentation development. A professional presentation was developed, comprised of information discovered in the literature review and information obtained from field consultants. The presentation included a discussion on male depression, family and relational dynamics that accompany depression in males, and cultural factors impacting men with depression.

Presentation delivery. This presentation was presented at Alafia Mental Health Institute in Lancaster, CA, a community mental health center. The material presented was directed toward mental health professionals working with families of various cultural backgrounds. The goal of the presentation was to highlight the significance of fathers within the family and to encourage involvement of fathers in treatment, as well as increase awareness of issues that these fathers may be facing individually and systemically.

Presentation evaluation. A questionnaire was utilized to evaluate the presentation. Attendees of the presentation were given the questionnaire and asked to complete it at the end of the presentation. The author received assistance from the California School of Professional Psychology to develop the questionnaire. Questions assessed information such as the clarity and effectiveness of the presenter, relevance and applicability of the information in the presentation, and the degree to which the presentation was reflective of the objectives of the overall project. The academic advisor and the academic consultant evaluated the author's accuracy in addressing and responding to the goals and objectives of the doctoral project.

CHAPTER IV

Professional Input and Feedback

Field Consultant Interviews

Three field consultants were found through networking with professionals, academic instructors and professional websites. They were contacted via electronic mail and telephone calls. Interviews were conducted in person, in each of their professional offices. They were provided with information about the doctoral project, the role of the field consultant, methods of conducting consultation, and a list of interview questions that would be asked during the consultation (see Appendix B). The field consultants were asked to give their written consent affirming their awareness and understanding of their role as a field consultant. The field consultants that participated in this doctoral project have experience and knowledge in the areas of men's issues as well as an understanding of cultural issues involved in men's issues and depression.

The field consultants were asked about their clinical experiences of effective interventions for addressing depression in men. A common theme that emerged as part of this question was the importance of engagement and creation of a safe, non-judgmental environment in therapy. According to one field consultant, if a man is not strongly engaged during the first session, it is unlikely that he will return for a second session. Men want to feel that a therapist is capable of engaging them in constructive and beneficial process. One of the field consultants suggested that even the sensory experience of the therapist's office can help with the initial process of engagement –

using neutral colors in the office, leather chairs in the waiting room, and inclusion of sports magazines in the reading material in the waiting room.

Accurately diagnosing depression is essential to effective treatment of depressed men. It can be helpful to assess for depression during the intake and beginning stage of therapy, keeping in mind the common symptoms and presentation of depression in male clients. Generally when a man enters therapy, he is in significant distress. Part of engaging male clients is validating and showing compassion for them, using male-friendly language. Asking them openly about their fears and concerns can aid the engagement process as well, because it gives them a chance to share what may be holding them back from fully connecting with the therapist and the process.

The next question that was asked was about therapist gender and its impact on the effectiveness of treatment with depressed men. The responses from field consultants on the issue of therapist gender were mixed. Two of the field consultants noted that in their experience, the best match for a male client is a female therapist. One explained that the primary caretaker in a child's life is usually a woman, and early object issues tend to center around a woman's love. However, in order to be aligned with masculine identity, males are expected to give up the closeness of their relationship with their mothers early in life and resist expression of grief over this loss. Females are not socially expected to grow more distant in that relationship in the same way as they grow older. The distance of the relationship with the primary love object may be a male's first experience of denying their needs and emotions in order to meet the culture's expectations of masculinity. Therefore, there are extensive opportunities for female therapists to utilize transference issues with their male clients. Transference may be stirred up within the

context of the female therapist as a friend, a mother, an erotic fantasy, or a romantic relationship. Both of these field consultants said that in their experience, the main emotion or experience that is brought up for male clients with other males, including therapists, is competition. Men are socialized to encourage each other to "man up" or be brave in difficult circumstances, so it may be difficult for a male client to see a male therapist as having the capacity for empathy and interest in his emotional experiences.

The third field consultant expressed the belief that while men who endorse more traditional gender roles may be willing to go deeper with a female therapist, both male and female therapists can work effectively with men. The most important variable, more significant than therapist gender, is the therapist's familiarity with men's issues. A male therapist who works with couples may benefit in that couples will often seek out a male therapist in particular, due to men's fear that a female therapist could align with the female partner.

The field consultants were asked for their opinions and clinical judgment about involving children in treatment of depressed men. Specifically, they were asked whether or not children should receive psychoeducation about the struggles of their depressed fathers, and if so, the factors that determine this decision, such as age and method of intervention. Several factors contribute to the decision about whether or not to inform children about the struggles of their depressed fathers. Child's age and maturity level are important components to consider, and this was a common response among all of the field consultants. However, an age "cutoff" for consideration of child psychoeducation was difficult to pinpoint, because there are many variables to consider. The child's developmental age is generally more significant than chronological age, because it

informs the language and content of the discussion that a family member or therapist may have with a child. The types of questions that a child is asking are also useful pieces of information, and can help facilitate family communication about a father's depression. All of the field consultants noted that if a father's depression is impacting a child, it is very important not to allow it to remain unaddressed, and therapists can help parents to communicate with their children about difficult issues.

The context of the depression is another factor to consider related to this topic. In the case of more chronically depressed fathers, children may see their fathers' behavior as personality traits or characteristics. Fathers experiencing situational depression, or depression with a more recent onset, may have children who notice that the fathers' behavior is incongruent with past behavior. The type of behavior exhibited by fathers is very important to assess as well. Fathers with symptoms of withdrawal and avoidance may appear aloof and uninterested their children, and it may be helpful to assist children in understanding that this behavior does not have anything to do with them, but that their father is struggling because of other reasons. Children are naturally egocentric, and will often interpret others' behavior through the lens of the self. Other fathers may be engaged in high-risk behaviors such as substance abuse and violence, and in this situation, an intervention centered on child safety is needed. It is especially important for children who have experienced abuse or neglect from their fathers to understand that it is never permissible for an adult to treat a child this way.

Lastly, it may be very healing to facilitate a family atmosphere where a father can be genuine with his needs. Depressed men may feel a great deal of pressure to meet expectations, and feel shame as a result of perceived failure. Therapists can work with

family members to help them develop empathy for fathers, and also to guide fathers to be able to communicate their needs. For example, a therapist may ask a father the ways in which his family can help him during a time of distress, and give him the opportunity to voice what would be helpful.

The field consultants were asked to provide input on how a clinician's cultural background might impact the course of treatment with depressed men. One of them noted that all cultures hold different ideas about what it means to be a father. A male client may benefit by exploring his relationship with his father – for example, the cultural expectations of his father around the idea of fatherhood, his father's expression of anger and sadness, and the level of openness in communication between him and his father. Issues in the client's family of origin can be a rich source of information about the client. Some men may prefer to see a therapist with a similar cultural background, believing that he or she will be able to understand his experiences more easily. Others may, however, simply desire to see a therapist who is knowledgeable about the issues with which he presents, regardless of cultural background.

Culture appears to be a filter for the expression of depression in men. The experience of depression is universal, but the way it manifests depends in part on a man's cultural background and identification. Some cultures tend to value externalization of symptoms, while others tend to endorse more internalizing behaviors, and men tend to act accordingly. As such, depression in men may manifest either by internalizing symptoms such as numbing or avoidance, or externalizing symptoms such as hostility, aggression, risk-taking behaviors, substance abuse, and sexual escapism, and cultural adherences may filter the experience of depression. In light of this, the Internet has become a dangerous

outlet for men. In previous decades, men who were seeking sexual escapism visited prostitutes or engaged in extramarital affairs – both activities that carry a risk of pregnancy and sexually transmitted diseases. However, men today are capable of having a completely different life over the internet without the consequences typically associated with sexual escapism. This psychologist also explained that cultural shifts in the United States regarding family structure have left many men lost and searching for their role, which has changed dramatically over the past few decades. With women often assuming the roles previously allotted to men and taking on more responsibilities, men today have become less sure of their place and purpose. This psychologist has also witnessed a rise in the instances of female-initiated divorces leading to depression in men, and attributes this in part to changes in the cultural landscape.

The field consultants were asked about ways in which clinicians can show respect and honor the dignity of depressed male clients from various cultural backgrounds while directly addressing clinical issues. Two of the field consultants stressed the positive effect of taking a strengths-based approach with male clients. This includes a genuine curiosity about the client, absence of judgment or condemnation in the face of resistance, and establishment of good intentions from the very first session. Men often present to therapy with some apprehension around what the therapist may try to do with them. They may believe that the therapist will try to fix something that is wrong or broken within them. Therapists can address this directly and warmly by explaining that their job is not to fix something about their clients, but to enhance the skills that their clients already possess and use them as tools in the process. Men may also fear that therapists will force them to talk about their emotions. This can be addressed by speaking openly with male clients

about how they conduct sessions, and by debunking some of the myths of therapy. Creating goals collaboratively with clients will also help therapists uphold male clients' dignity, because the clients will then be specifically seeking change in certain areas.

The language of men and women differs as well. One field consultant noted that if men curse or use strong language in sessions, it may actually enhance the therapeutic process if the therapist uses the same or similar language at appropriate times. It can help to let clients know, verbally or nonverbally, that it is okay if they need to curse or cry. If it appears that a male client is holding back or masking emotions, it may be helpful to depersonalize the experience for them to make it more manageable. For example, a therapist could say to a client, "You mentioned that you were angry about what happened. While you were talking about that, I felt a little sad," and then wait to hear how he responds. Overall, therapists should convey to these clients that they truly value whatever they are told, and that the therapist is conscientious (arriving to session on time, returning clients' phone calls, doing what they said they would do). This will be very meaningful for clients who expect to be dismissed or have a history of being dismissed.

Perceived weakness and shame are significant components of depression in men. The field consultants were asked to discuss what they have noticed as some of the factors in life and society that have tended to lead to perceived weakness and shame in their depressed male clients, and whether these factors vary by cultural background. From the time that men are born, they are given constant, strong messages that they must be strong. One field consultant explained the socialization process quite eloquently. Men are given messages when they are children that the only appropriate way to handle feelings is to get them out of the way so that they can behave through the lens of rationality. As people age,

they should begin to learn that there is room after emotion and before behavior, and cognitive variables can be used in this space (religion and morality, for example). But men are often not taught about emotion socialization, and are not given the skills to integrate emotion and behavior. Often they try to eradicate the feeling as quickly as possible so that it does not reflexively determine their behavior, and they may even become frightened of what they may do if they experience an emotion. On the other hand, exhaustive effort may be put into repressing those feelings and this frequently leads to emotional numbing. In either situation, their judgment is impaired and decision-making can be poor when emotions are activated.

The construct of "strength" is very broad and has vastly different meanings for every individual, but the perceived failure to uphold the standard of strength is very shaming for men. One field consultant stated that the most common presenting problems with depressed men are sexual issues, economic issues like unemployment, and failure to provide emotionally or financially for a partner or family. These factors vary by cultural background in that all cultures define strength differently. For each cultural group, shame will likely be experienced when a man does not live up to the standard of strength. The man's experience will depend on the level to which he has internalized the standard of strength.

The final question for the field consultants was about their experience of working with shame and vulnerability in men, and they were asked to discuss what this experience was like for them. Working with shame and vulnerability in the therapy room was explained by one field consultant as an extremely profound and powerful experience. What makes it so powerful is that while women tend to talk about their emotional pain

with ease and in some ways have become desensitized to the experience, men rarely do so. When a man opens the door to a discussion of his shame, it is a defining moment for him. This field consultant also noted that it may not be in the best interest of the client to expose himself to this level of vulnerability with everybody around him, but it is most important that he exposes these painful emotions and ensuing vulnerability with himself first and foremost. Then, when he becomes comfortable with this, it may be healing to introduce it to a primary relationship (for example, opening a discussion with a wife or a close friend). The experience for a therapist of a male client bringing true vulnerability into the room is one that is felt viscerally, and is difficult to confine into language. Therapists should view this moment as a highly courageous act, and convey respect for men who trust them deeply enough to share these parts of themselves in session.

The moment that men expose their shame and vulnerability in the therapy room was also described by one field consultant as an opportunity for therapists to speak with clients nonjudgmentally about what triggers their shame, and explore gender socialization and other contributing factors. It can help to free clients of constraining gender expectations and to delve deeply into the clients' feelings. Another field consultant explained that men put a great deal of effort into protecting their reputation and projecting an image of confidence and strength. They have been socialized strongly against the display of vulnerability. This is precisely what makes the experience of a male client exposing his deepest sources of shame to a therapist so powerful.

Professional Presentation Evaluation

A professional presentation on the doctoral project topic was given at Alafia Mental Health Institute in Lancaster, CA, on October 30, 2013. Evaluations were

obtained from attendees of the presentation in the form of questionnaires handed to them after the presentation (See Appendix C). Questions on the evaluation assessed information such as the clarity and effectiveness of the presenter, relevance and applicability of the information in the presentation, and the degree to which the presentation was reflective of the objectives of the overall project. Ten people were in attendance, and all ten completed the evaluations. There was one licensed professional in marriage and family therapy (MFT), one unlicensed registered psychologist, one unlicensed MFT intern, one psychological assistant in private practice, two predoctoral interns (one in a forensic Psy,D. program and another in a clinical Psy.D. program), two unlicensed social work professionals, and two who did not provide information about the capacity in which they provide services.

The evaluation used a Likert scale with “1” meaning “Not at all,” “3” meaning “Somewhat,” and “5” meaning “Very much,” to assess various aspects of the presentation. When attendees were asked how familiar they were with the topic of paternal depression before the presentation, five people reported they were not familiar at all, four people responded that they were somewhat familiar, and one person responded that they were more than somewhat familiar. The evaluation then asked how much the presenter increased their knowledge about the topic, to which two people responded that they were somewhat familiar, four people responded that they were more than somewhat familiar, and four people responded that they were very familiar with the topic. The next question asked how useful the information presented was as a clinician or professional working with men who show signs of depression, and one person responded that the information was somewhat useful, two people responded that it was more than somewhat useful, and

seven people responded that it was very useful. When asked about the presenter's overall ability to communicate the information presented, one person responded that the presenter did a satisfactory job of presenting the information, five people responded that it was more than satisfactory, and four people responded that it was very good. The evaluation then asked how well the presenter handled questions from the audience, to which two people responded that the presenter handled questions well, and eight people responded that questions were handled very well. When asked about how helpful the presentation slides were, two people responded that they were somewhat helpful, five people responded that they were more than somewhat helpful, and three people responded that they were very helpful. Then, the questionnaire asked how helpful the handouts were, to which two people responded that the handouts were somewhat helpful, three people responded that they were more than somewhat helpful, and five people responded that they were very helpful.

The presentation evaluation also addressed most beneficial areas of the presentation as well as areas for improvement. On a question that asked what each attendee liked most about the presentation, two people referenced the section on cultural considerations and implications, one person said that it was well-organized, one person stated that the handout with the list of symptoms was helpful, two people brought up the videos played during the presentation that showed real cases of men with depression, one person said he or she enjoyed that the presentation topic was on an under-represented population, and one person discussed that the information presented was new and informative, and not something he or she had considered. Two people left this question blank. When asked what they liked least about the presentation, one person stated that he

or she would have liked it if the presenter had interacted more with the audience. One person said that it was a drawback that there was no PowerPoint presentation (paper handouts of the presentation were provided [see Appendix D], but there was no projector available with which to display it electronically). Of the three videos included in the presentation, one video did not work due to a website issue, and one person said that he or she would have liked it if the first video of three had worked. Another person stated that there was not enough detail in the presentation and attributed this to the breadth of the subject matter. Six people did not answer the question (either by leaving it blank, stating "N/A," or writing "nothing").

The next question on the evaluation asked attendees to describe how this information will be useful in their work with clients. One person said that the information from the presentation would, in the future, facilitate the recognition the signs of depression in men. Five people indicated that they were now able to understand how male depression impacts their families, and some of these responses described being motivated to look into fathers' mental health more within the family context. One person said that he or she had learned about how to approach this subject in clinical work with males, because this was not provided in his or her graduate training. One person mentioned that mothers have typically taken over in the children's treatment and that the presentation conveyed useful information for encouraging the father's involvement, and that the information learned will help him or her to address depression in the boys seen in therapy. One person said it was helpful that the presentation highlighted that all men have special needs to consider in treatment. One person who does not work with clients directly wrote "N/A."

Next, the attendees were asked to provide suggestions to help improve this presentation and make it more useful for other audiences. One person stated that while the consideration of "minority" cultures and depression was appreciated, the lack of discussion on Caucasian men in this section could give the impression that Caucasian men have been exempt from consideration or that depression has not been an issue among whites, which may be off-putting to people of color. Another person suggested that the handout provided could have been improved by adding more detailed information that was shared verbally in the presentation. It was also suggested that more handouts or information on effective techniques or strategies to engage men could have been useful. One person mentioned it could be helpful to create a handout that clinicians could hand out to clients or families. It was noted that the presenter's speed was problematic, and two people noted that it would be very helpful if the presenter spoke more slowly and in a more conversational manner with the audience, rather than reading from presentation notes. Case vignettes and additional videos were also brought up as a way to improve the presentation. Two people did not answer this question.

Generally, the presentation was evaluated as a positive and informative experience for the audience, with some highlights being the topic of the presentation focusing on an under-represented population, engaging videos, and clinically relevant handouts. Some of the areas that the attendees noted could have been improved were the presenter's speed and manner of presenting, creation of more handouts that clinicians can utilize, and increased inclusion of Caucasian men in the discussion of cultural considerations. Additionally, attendees enjoyed the videos, and suggested that more videos and case vignettes be included in the future.

CHAPTER V

Discussion

The information presented in the literature review introduced a variety of important factors to consider when addressing depression in men. It described societal, cultural, familial, and personal implications of male depression, and offered insight into some of the factors that have perpetuated concealment of depression in the male population. Much of the research can be directly applied to clinical practice – if practitioners know how paternal depression affects families and the fathers themselves, steps can be taken to proactively address problem areas that typically follow. With more knowledge on the presentation and manifestations of paternal depression available to clinicians to help them properly diagnose depression in males, clinicians can also diagnose with more accuracy and conceptualize cases through the lens of male depression. However, the literature also raised questions that were left as somewhat of a mystery. Additionally, several limitations were clearly present within the confines of the literature review. In this section, new questions raised by the literature were discussed, as well as the limitations of the literature review. A personal reflection was also included, which spoke about the process of creating this project.

Limitations

The study of depression in fathers has grown quickly within the past decade, and it has been encouraging to see the increasing number of researchers interested in examining this population. However, as is typically the case with relatively new areas of interest, the number of studies that directly addressed depression and fatherhood has been limited. In order for specific topics in the literature review to be covered, research

addressing related topics needed to be utilized. For example, some studies addressed parenting styles of depressed parents while other studies addressed how those practices affect children, but no study was found that utilized depressed men as their sample and examined the effects of depression on parenting styles and child adjustment in turn. Because several related studies and few direct studies were pulled together to draw a conclusion in specific sections, the reader should be discerning when considering how the research has been used for the purposes of this literature review.

Definition of depression. A significant limitation of this review was the ambiguity regarding the definition of depression. Many studies defined depression as simply reaching a cutoff point on a depression questionnaire. While this technique has been a useful tool in gauging general depressive symptomatology, it also may have excluded other individuals who meet criteria for the disorder, but with alternatively presenting symptoms (e.g., anger, hostility, hypersexuality). This definition also included those who have experienced symptoms but who have not had a disorder. The studies addressing depression typically referred to "depressive symptoms" rather than "depressive disorder." Men who have showed depressive symptoms may not have necessarily received a diagnosis of a depressive disorder, and the results of these studies may have changed if they included in their sample only those who truly have a diagnosis of a depressive disorder. This distinction was significant in that depressive symptoms alone may have been signs of an unrelated problem, like an adjustment or transition, a medical problem, or a host of other difficulties. Those who have suffered from a depressive disorder may have behaved differently or required different treatment from those with depressive symptoms stemming from other sources. The distinction was quite

elusive, however, given the relatively new understanding in the field of male-type depression.

Methodology. Many of the studies included in the literature review used samples and methods that may have obscured results. One example of this was the type of assessment tools used in methods sections. Self-report measures were used on several of the studies included. For example, men were asked to report their own depressive symptoms on most of the studies assessing depression. As described in the literature review, men with depression may have felt ashamed and tried to conceal their depression, or they may have manifested their depression in atypical ways. Self-report measures for depressed men may not have been an accurate assessment tool. A more accurate representation of the depressed male population may have been attained by supplementing a self-report measure with a clinical interview and psychological history, though these methods may have been time consuming and expensive.

Diversity. Lack of diversity within samples used in the research was a major limitation of this literature review. As briefly discussed in the literature review, a large number of studies included samples comprised almost completely of Caucasian, middle class individuals. These samples also tended to be quite similar in level of education and income. Homogenous samples such as these were clearly not representative of the United States population, and thus, generalizability to the national population may not have been appropriate. The use of more diverse populations in the samples would likely alter outcomes and produce different results in several of the studies. The experience of Caucasian, middle-class individuals has differed significantly from that of individuals of other cultural backgrounds or socioeconomic status. However, accessing diverse

populations may have been very difficult for some of the researchers (for example, in universities where the student population itself did not possess much diversity). The studies that lacked diversity still contained very valuable pieces of information and promoted insight into areas that have not been thoroughly researched, and may serve as a springboard for others to continue studying these areas using more diverse populations.

Family structure has undergone shifts and changes over the years, but most of the studies involving families have not reflected the strong presence of nontraditional families. As a requirement to participate in many of the studies, participants must have been a part of a two-parent family, and couples needed to have been living together for a specific amount of time. This excluded a variety of families across the nation: families with single parents, families with divorced parents, families with parents that did not live together, or families that were formed recently are not accounted for in these studies. Generalizability to the population also became questionable due to the lack of diversity in family structure represented in the research. Nontraditional families may have had different dynamics, difficulties, and strengths than the traditional families in the study samples, and more research with nontraditional families could have been helpful in identifying family processes that were more generalizable.

A prominent hole in the literature review was its failure to address issues related to gay fathering and dynamics within families with two fathers. This topic could be a complete area of study in itself, and it would be very difficult to include sufficient information on this topic within the confines of the review. However, this was an extremely important area of study, and it was crucial to acknowledge it as such. As mentioned in the previous paragraph, family structure has changed dramatically over the

past few decades, and the experiences of families with a two-parent heterosexual household have not been identical to the experiences of families with a two-father household. For more information on dynamics of families with two fathers, see Goldberg and Allen (2012) and Goldberg (2012).

Another demographic area that was left out of the literature review was the impact of spirituality on the topic of paternal depression. This was important for two reasons. First, different religions and cultures have had varying interpretations of the cause for depression and depressive symptoms. Second, the role of a father has varied significantly across religions and spiritual backgrounds. The way that a father has been expected to behave, contrasted with the presentation of depressive symptoms, has been interpreted differently across these spiritual cultures. This was omitted from the literature review because, like gay fathering, to comprehensively cover this topic would have been difficult within the context of the review. There are numerous spiritual backgrounds, and it would have been difficult to cover all faiths thoroughly enough to provide even a basic background to the reader. As with any aspect of cultural identity, exploration of cultural expectations in spirituality and religion is needed. Even within many faiths, there are subgroups that have differed significantly from one another. Clinicians should be careful not to assume expectations based on what they know of a particular faith, but to ask questions and show respect for beliefs held by the client.

The limitations of the literature used in this doctoral project included difficulty pinpointing a definition of depression, use of self-report measures to examine depression in a population that tends to conceal their symptoms or manifest them differently, and little cultural and economic diversity, which rendered much of the research without

generalizability. In addition, some populations were left out of the literature review due to issues of breadth of coverage – non-traditional family structures have had their own distinct bodies of research, and it was not possible to include each type of family structure and each culture in existence. Because of these factors, readers should interpret the findings with caution and use discernment when generalizing to the population.

Recommendations for Further Research

The literature review described correlations and descriptive information about paternal depression and the way it presented intrapsychically and within the family. Relationships between fathering and depression were discussed, along with several other variables, such as relational and marital dynamics, substance abuse, help-seeking, child cognitive development, and culture. The review was limited, however, in describing why some of these dynamics occur. Few research articles addressed the issue of paternal depression and its manifestations and areas of impact directly, so the research articles required some assembly to connect different topics with one another. Future research directly addressing paternal depression and related topics would be very enlightening, as it may provide some information about the mechanisms and reasons behind these dynamics.

Some of the research pointed toward adolescent girls being particularly vulnerable to the effects of negative parenting practices, such as hostility. It would be interesting to see more research in the future to address this topic, and delve into some of the possible reasons that this particular relationship is vulnerable to this specific stress. More research in this area could be very valuable in treatment of adolescent girls and could help clinicians determine an appropriate course of action to address this father-daughter

relationship in therapy. Also, it would be enlightening to study which specific areas of the father-child relationship are impacted for both adolescent girls and adolescent boys.

The issue of shame and its connection with depression seemed to be a treasure trove of exciting research opportunities. We know that shame has been connected with depression in men, but less clear was how they have been connected, and what the specific contributors of shame have been for men of various cultural backgrounds. Brene Brown (2012) pinpointed society's expectation for men to be tough, and the intense pain that can come with a feeling of being perceived as weak. But what has caused this feeling of weakness? Surely weakness has various meanings and implications for men, depending on age, ethnicity, family background, spirituality, geographical location and other aspects of cultural identity. It would be interesting to discover what some of these sources of weakness have been for men, depending on culture and identity. Conversely, the construct of strength, particularly as it has related to manhood and fatherhood, has varied greatly between different cultures. For example, machismo has been the generally upheld standard of manhood in Latino cultures, and has reflected a man's ability to be physically strong, courageous and powerful, and to be a protector (Fragoso & Kashubeck, 2000). It would naturally follow that perceived failure to live up to these expectations would create a sense of shame, but it would be a great step to directly research these ideas and discover the causes of shame across various cultures, to understand what clinicians can do to address the issue of shame in a culturally sensitive way.

Personal Reflections and Critique

The creation of this doctoral project has been a highly enlightening process. I began the project by searching for articles that directly addressed paternal depression and its consequences and implications, but quickly discovered that the research is not neatly categorized, but rather exists in many scattered pockets of information. I was aware from the beginning that there was limited research on the topic, but I had expected that it would be more centralized. However, there were fewer inherent connections in the literature than I had anticipated, which afforded me the opportunity to weave the information and research together to create a sense of cohesion.

A challenging aspect of this project was determining which subtopics should be covered, and which subtopics were not essential to the project, knowing that these decisions would inevitably leave some ground uncovered. The literature was vaguely self-categorized by topic, but there were many other aspects of paternal depression that were ancillary to the subject but not unrelated. Issues of culture and family structure often fell in this category. For example, while I determined that the family system was an essential subtopic to include in the project, it was less clear to me how in-depth I should go with it. I considered including research on divorced families, single-parent families, and families with two same-sex parents (the vast majority of research on families did not cover these families), but felt that although this is important information, it would be easy to veer off into different directions like this on all of the sections. It would not have been possible for me to cover all of these more specified subjects for each of the topics presented in the literature review, but it was difficult to make these important decisions about what to include.

The experiences I found most rewarding were the interviews with the field consultants, in which I had the opportunity to speak with professionals in the field who have a particular interest in men's issues. Their enthusiasm about the topic and their professional insights and relevant experiences with clients ignited a spark of passion in me and made the project become real, personal, relevant and powerful. They spoke not only about their clinical experiences, but also their professional perceptions about the problem of depression in men and related issues. The research covered in the literature review was very informative and enlightening, but the face-to-face interviews gave the project a breath of new life.

It was difficult to assign language to the general experience of completing this project – it was exciting, frustrating, fascinating, discouraging, and exhilarating. This has been an extremely relevant and important topic in the field of mental health that has been somewhat overlooked until recently, and as a result, I faced both discouragement at the idea that the research was as disjointed as it was, and encouragement about the research that already existed. More creativity was involved than I had anticipated, and I had to take a more active role than I expected in order to create a cohesive whole from the sources of information that covered vastly different areas of the topic. Overall, I hoped that this project connected some of the pieces in a meaningful way that may provide direction for future research and clinical practice.

REFERENCES

Addis, M. E. (2008). Gender and depression in men. *Clinical Psychology: Science and Practice, 15*(3), 153-168. http://dx.doi.org/10.1111/j.1468-2850.2008.00125.x

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5-14. http://dx.doi.org/10.1037/0003-066X.58.1.5

American Association of Suicidology. (2010). *Facts about suicide and depression based on 2010 data* [Fact sheet]. Retrieved from http://www.suicidology.org/resources/facts-statistics-current-research/fact-sheets

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Angst, J., Gamma, A., Gastpar, M., Lepine, J.-P., Mendlewicz, J., & Tylee, A. (2002). Gender differences in depression: Epidemiological findings from the European DEPRES I and II studies. *European Archives of Psychiatry and Clinical Neuroscience, 252*(5), 201-209. http://dx.doi.org/ 10.1007/s00406-002-0381-6

Ashby, J. S., Rice, K. G., & Martin, J. L. (2006). Perfectionism, shame, and depressive symptoms. *Journal of Counseling & Development, 84*(2), 148-156. http://dx.doi.org/10.1002/j.1556-6678.2006.tb00390.x

Beam, C. R., Horn, E. E., Hunt, S. K., Emery, R. E., Turkheimer, E., & Martin, N. (2011). Revisiting the effects of marital support on depressive symptoms in mothers and fathers: A genetically informed study. *Journal of Family Psychology, 25*(3), 336-344. http://dx.doi.org/10.1037/a0023758

Bennett, L. W. (2008). Substance abuse by men in partner abuse intervention programs: Current issues and promising trends. *Violence and Victims, 23*(2), 236-248. http://dx.doi.org/10.1891/0886-6708.23.2.236

Besinger, B. A., Garland, A. F., Litrownik, A. J., & Landsverk, J. A. (1999). Caregiver substance abuse among maltreated children placed in out-of-home care. *Child Welfare League of America, 78*(2), 221-239. Retrieved from http://www.cwla.org/articles/cwjabstracts.htm

Bowman, P. J. (1992). Coping with provider role strain: Adaptive cultural resources among black husband-fathers. In A. K. H. Burlew, W. C. Banks, H. P. McAdoo, & D. A. ya Azibo (Eds.), *African American psychology: Theory, research, and practice* (pp. 135-154). Newbury Park, CA: Sage.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32*(7), 515-531. http://dx.doi.org/10.1037//0003-066X.32.7.513

Brown, B. (2012, March). *Brené Brown: Listening to shame* [Video file]. Retrieved from the TED Conferences website: http://www.ted.com/talks/brene_brown_listening_to_shame.html

Brown, G. L., McBride, B. A., Shin, N., & Bost, K. K. (2007). Parenting predictors of father-child attachment security: Interactive effects of father involvement and fathering quality. *Fathering: A Journal of Theory, Research, and Practice about Men as Fathers, 5*(3), 197-219. http://dx.doi.org/10.3149/fth.0503.197

Cabrera, N. J., & Bradley, R. H. (2012). Latino fathers and their children. *Child Development Perspectives, 6*(3), 232-238. http://dx.doi.org/10.1111/j.1750-8606.2012.00249.x

Cabrera, N. J., Shannon, J. D., & Tamis-LeMonda, C. (2007). Fathers' influence on their children's cognitive and emotional development: From toddlers to Pre-K. *Applied Developmental Science, 11*(4), 208-213. http://dx.doi.org/10.1080/10888690701762100

Celano, M., Bakeman, R., Gaytan, O., Smith, C. O., Coki, A., & Henderson, S. (2008). Caregiver depressive symptoms and observed family interaction in low-income children with persistent asthma. *Family Process, 47*(1), 7-20. http://dx.doi.org/10.1111/j.1545-5300.2008.00236.x

Chen, G. A. (2009). Managing multiple social identities. In N. Tewari & A. N. Alvarez, (Eds.), *Asian American psychology: Current perspectives* (pp. 173-192). New York, NY: Taylor & Francis.

Cheung, M. S.-P., Gilbert, P., & Irons, C. (2004). An exploration of shame, social rank and rumination in relation to depression. *Personality and Individual Differences, 36*(5), 1143-1153. http://dx.doi.org/10.1016/S0191-8869(03)00206-X

Chuick, C. D., Greenfeld, J. M., Greenberg, S. T., Shepard, S. J., Cochran, S. V., & Haley, J. T. (2009). A qualitative investigation of depression in men. *Psychology of Men and Masculinity, 10*(4), 302-313. http://dx.doi.org/10.1037/a0016672

Cochran, S. V., & Rabinowitz, F. E. (2003). Gender-sensitive recommendations for assessment and treatment of depression in men. *Professional Psychology: Research and Practice, 34*(2), 132-140. http://dx.doi.org/10.1037/0735-7028.34.2.132

Crosby, A. E., Han, B., Ortega, L. A. G., Parks, S. E., & Gfoerer, J. (2011, October 21). Suicidal thoughts and behaviors among adults aged ≥ 18 years --- United States, 2008-2009. *Surveillance Summaries, 60*(SS13), 1-22. Retrieved from the Centers for Disease Control and Prevention website: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6013a1.htm?s_cid=ss6013a1_w

Culp, R. E., Schadle, S., Robinson, L., & Culp, A. M. (2000). Relationships among paternal involvement and young children's perceived self-competence and behavioral problems. *Journal of Child and Family Studies, 9*(1), 27-38. http://dx.doi.org/10.1023/A: 1009455514587

Cummings, E. M., Keller, P. S., & Davies, P. T. (2005). Towards a family process model of maternal and paternal depressive symptoms: Exploring multiple relations with child and family functioning. *Journal of Child Psychology and Psychiatry, 46*(5), 479-489. http://dx.doi.org/10.1111/j.1469-7610.2004.00368.x

Cunradi, C. B., Caetano, R., & Schafer, J. (2002). Alcohol-related problems, drug use, and male intimate partner violence severity among US couples. *Alcoholism: Clinical and Experimental Research, 26*(4), 493-500. http://dx.doi.org/10.1111/j.1530-0277.2002. tb02566.x

Dinh, K. T., & Nguyen, H. N. (2006). The effects of acculturative variables on Asian American parent-child relationships. *Journal of Social and Personal Relationships, 23*(3), 407-426. http://dx.doi.org/10.1177/0265407506064207

Dittman, C., Keown, L. J., Sanders, M., Rose, D., Farruggia, S. P., & Sofronoff, K. (2011). An epidemiological examination of parenting and family correlates of emotional problems in young children. *American Journal of Orthopsychiatry, 81*(3), 360-371. http://dx.doi.org/10.1111/ j.1939-0025.2011.01104.x

Du Rocher Schudlich, T. D., Papp, L. M., & Cummings, E. M. (2004). Relations of husbands' and wives' dysphoria to marital conflict resolution strategies. *Journal of Family Psychology, 18*(1), 171-183. http://dx.doi.org/10.1037/0893-3200.18.1.171

Elgar, F. J., Mills, R. S. L., McGrath, P. J., Waschbusch, D. A., & Brownridge, D. A. (2007). Maternal and paternal depressive symptoms and child maladjustment: The mediating role of parental behavior. *Journal of Abnormal Child Psychology, 35*(6), 943-955. http://dx.doi.org/10.1007/s10802-007-9145-0

Ennis, S. R., Rios-Vargas, M., & Albert, N. G. (2011, May). *The Hispanic population: 2010* (2010 Census Brief No. C2010BR-04). Retrieved from the U.S. Census Bureau website: http://www.census.gov/prod/ cen2010/briefs/c2010br-04.pdf

Evans, G. W. (2004). The environment of childhood poverty. *American Psychologist, 59*(2), 77-92. http://dx.doi.org/10.1037/0003-066X.59.2.77

Fals-Stewart, W. (2003). The occurrence of partner physical aggression on days of alcohol consumption: A longitudinal diary study. *Journal of Consulting and Clinical Psychology, 71*(1), 41-52. http://dx.doi.org/10.1037//0022-006X.71.1.41

Field, T. M., Hossain, Z., & Malphurs, J. (1999). “Depressed” fathers’ interactions with their infants. *Infant Mental Health Journal, 20*(3), 322-332. http://dx.doi.org/ 10.1002/(SICI)1097-0355(199923)20:3<322::AID-IMHJ8>3.3.CO;2-K

Focht-Birkerts, L., & Beardslee, W. R. (2000). A child’s experience of parental depression: Encouraging relational resilience in families with affective illness. *Family Process, 39*(4), 417-434. http://dx.doi.org/10.1111/j.1545-5300.2000.39403.x

Fragoso, J. M., & Kashubeck, S. (2000). Machismo, gender role conflict, and mental health in Mexican American men. *Psychology of Men and Masculinity, 1*(2), 87-97. http://dx.doi.org/10.1037//1524-9220.1.2.87

Franck, K. L. & Buehler, C. (2007). A family process model of marital hostility, parental depressive affect, and early adolescent problem behavior: The roles of triangulation and parental warmth. *Journal of Family Psychology, 21*(4), 614-625. http://dx.doi.org/10.1037/0893-3200.21.4.614

Gartstein, M. A., & Fagot, B. I. (2003). Parental depression, parenting and family adjustment, and child effortful control: Explaining externalizing behaviors for preschool children. *Applied Developmental Psychology, 24*(2), 143-177. http://dx.doi.org/10.1016/S0193-3973(03)00043-1

George, C., Herman, K. C., & Ostrander, R. (2006). The family environment and developmental psychopathology: The unique and interactive effects of depression, attention, and conduct problems. *Child Psychiatry and Human Development, 37*(2), 163-177. http://dx.doi.org/10.1007/s10578-006-0026-5

Goodman, S. H., Rouse, M. H., Connell, A. M., Broth, M. R., Hall, C. M., & Heyward, H. (2011). Maternal depression and child psychopathology: A meta-analytic review. *Clinical Child & Family Psychology Review, 14*(1), 1-27. http://dx.doi.org/10.1007/s10567-010-0080-1

Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, S. P., Dufour, M. C., Compton, W., . . . Kaplan, K. (2006). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 29*(2), 107-120. Retrieved from http://pubs.niaaa.nih.gov/publications/arh29-2/107-120.pdf

Greenfield, B. L., Venner, K. L., Kelly, J. F., Slaymaker, V., & Bryan, A. D. (2012). The impact of depression on abstinence self-efficacy and substance use outcomes among emerging adults in residential treatment. *Psychology of Addictive Behaviors, 26*(2), 246-254. http://dx.doi.org/10.1037/a0026917

Halgunseth, L. C., Ispa, J. M., & Rudy, D. (2006). Parental control in Latino families: An integrated review of the literature. *Child Development, 77*(5), 1282-1297. http://dx.doi. org/10.1111/j.1467-8624.2006.00934.x

Head, J. (2004). *Black men and depression.* New York, NY: Harlem Moon.

Hines, D. A., Brown, J., & Dunning, E. (2007). Characteristics of callers to the domestic abuse helpline for men. *Journal of Family Violence, 22*(2), 63-72. http://dx.doi.org/10.1007/ s10896-006-9052-0

Hunter, E. C., Katz, L. F., Shortt, J. W., Davis, B., Leve, C., Allen, N. B., & Sheeber, L. B. (2011). How do I feel about feelings? Emotion socialization in families of depressed and healthy adolescents. *Journal of Youth and Adolescence, 40*(4), 428-441. http://dx.doi.org/10.1007/s10964-010-9545-2

Iwamoto, D. K., & Liu, W. M. (2009). Asian American men and Asianized attribution. In N. Tewari & A. N. Alvarez (Eds.), *Asian American psychology: Current perspectives* (pp. 211-232). New York, NY: Taylor & Francis.

Jacob, T., & Johnson, S. L. (2001). Sequential interactions in the parent-child communications of depressed fathers and depressed mothers. *Journal of Family Psychology, 15*(1), 38-52. http://dx.doi.org/10.1037//0893-3200.15.1.38

Joiner, T. E., Alfano, M. S., & Metalsky, G. I. (1992). When depression breeds contempt: Reassurance seeking, self-esteem, and rejection of depressed college students by their roommates. *Journal of Abnormal Psychology, 101*(1), 165-173. http://dx.doi.org/10.1037//0021-843X.101.1.165

Kane, P., & Garber, J. (2008). Parental depression and child externalizing and internalizing symptoms: Unique effects of fathers' symptoms and perceived conflict as a mediator. *Journal of Child and Family Studies, 18*(4), 465-472. http://dx.doi.org/10.1007/s10826-008-9250-x

Katz, L. F., & Hunter, E. C. (2007). Maternal meta-emotion philosophy and adolescent depressive symptomatology. *Social Development, 16*(2), 343-360. http://dx.doi.org/10.1111/j.1467-9507.2007.00388.x

Kim, S. Y., Gonzalez, N. A., Stroh, K., & Wang, J. J. (2006). Parent-child cultural marginalization and depressive symptoms in Asian American family members. *Journal of Community Psychology, 34*(2), 167-182. http://dx.doi.org/10.1002/jcop.20089

Kramer, E. J., Kwong, K., Lee, E., & Chung, H. (2002). Cultural factors influencing the mental health of Asian Americans. *Western Journal of Medicine, 176*(4), 227-231. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071736/pdf/wjm17600227.pdf

Laslett, A. M., Room, R., Dietze, P., & Ferris, J. (2012). Alcohol's involvement in recurrent child abuse and neglect cases. *Addiction, 107*(10), 1786-1793. http://dx.doi.org/10.1111/j.1360-0443.2012.03917.x

Lester, D. (1998). The association of shame and guilt with suicidality. *The Journal of Social Psychology, 138*(4), 535-536. http://dx.doi.org/10.1080/00224549809600407

Lim, J., Wood, B. L., Miller, B. D., & Simmens, S. J. (2011). Effects of paternal and maternal depressive symptoms on child internalizing symptoms and asthma disease activity: Mediation by interparental negativity and parenting. *Journal of Family Psychology, 25*(1), 137-146. http://dx.doi.org/10.1037/a0022452

Liu, W. M., & Iwamoto, D. K. (2006). Asian American men's gender role conflict: The role of Asian values, self-esteem, and psychological distress. *Psychology of Men & Masculinity, 7*(3), 153-164. http://dx.doi.org/10.1037/1524-9220.7.3.153

Low, S. M., & Stocker, C. (2005). Family functioning and children's adjustment: Associations among parents' depressed mood, marital hostility, parent-child hostility, and children's adjustment. *Journal of Family Psychology, 19*(3), 394-403. http://dx.doi.org/10.1037/0893-3200.19.3.394

Marchand, J. F., & Hock, E. (2000). Attacking conflict-resolution strategies among married couples: Relations to depressive symptoms and marital satisfaction. *Family Relations, 49*(2), 201-206. http://dx.doi.org/10.1111/j.1741-3729.2000.00201.x

Marchand, J. F., & Hock, E. (2003). Mothers' and fathers' depressive symptoms and conflict resolution strategies in the marriage and children's externalizing and internalizing behaviors. *Journal of Genetic Psychology, 164*(2), 227-239. http://dx.doi.org/10.1080/ 00221320309597979

Mezulis, A. H., Hyde, J. S., & Clark, R. (2004). Father involvement moderates the effect of maternal depression during a child's infancy on behavioral problems in kindergarten. *Journal of Family Psychology, 18*(4), 575-588. http://dx.doi.org/ 10.1037/0893-3200.18.4.575

Miller, S. R., Murry, V. M., & Brody, G. H. (2005). Parents' problem solving with preadolescents and its association with social withdrawal at school: Considering parents' stress and child gender. *Fathering: A Journal of Theory, Research, and Practice about Men as Fathers, 3*(2), 147-163. http://dx.doi.org/ 10.3149/fth.0302.147

Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University.

Nicholson, J. S., Deboech, P. R., Farris, J. R., Boker, S. M., & Borkowski, J. G. (2011). Maternal depressive symptomatology and child behavior: Transactional relationship with simultaneous bidirectional coupling. *Journal of Developmental Psychology, 47*(5), 1312-1323. http://dx.doi.org/10.1037/a0023912

Oren, C. Z., & Oren, D. C. (2010). *Counseling fathers.* New York, NY: Routledge.

Pan, B. A., Rowe, M. L., Singer, J. E., & Snow, C. E. (2005). Maternal correlates of growth in toddler vocabulary production in low-income families. *Child Development, 76*(4), 763-782. http://dx.doi.org/10.1111/1467-8624.00498-i1

Pancsofar, N., Vernon-Feagans, L., & The Family Life Project Investigators. (2010). Fathers' early contributions to children's language development in families from low-income rural communities. *Early Childhood Research Quarterly, 25*(4), 450-463. http://dx.doi.org/10.1016/j.ecresq.2010.02.001

Parke, R. D., Coltrane, S., Duffy, S., Buriel, R. Dennis, J. Powers, J., . . . Widaman, K. F. (2004). Economic stress, parenting, and child adjustment in Mexican American and European American families. *Child Development, 75*(6), 1632-1656. http://dx.doi.org/10.1111/ j.1467-8624.2004.00807.x

Pougnet, E., Serbin, L. A., Stack, D. M., & Schwartzman, A. E. (2011). Fathers' influence on children's cognitive and behavioural functioning: A longitudinal study of Canadian families. *Canadian Journal of Behavioural Science/Revue Canadienne des Sciences du Comportement, 43*(3), 173-182. http://dx.doi.org/1 0.1037/a0023948

Reeb, B. T., & Conger, K. J. (2009). The unique effect of paternal depressive symptoms on adolescent functioning: Associations with gender and father-adolescent relationship closeness. *Journal of Family Psychology, 23*(5), 758-761. http://dx.doi.org/10.1037/ a0016354

Reeb, B. T., Conger, K. J., & Wu, E. Y. (2010). Paternal depressive symptoms and adolescent functioning: The moderating effect of gender and father hostility. *Fathering: A Journal of Theory, Research, and Practice about Men as Fathers, 8*(1), 131-142. http://dx.doi.org/10.3149/ fth.0801.131

Reilly, E. D., Rochlen, A. B., & Awad, G. H. (2013, February 18). Men's self-compassion and self-esteem: The moderating roles of shame and masculine norm adherence. *Psychology of Men and Masculinity.* (n.p.). Advance online publication. http://dx.doi.org/10.1037/a0031028.

Roberts-Douglass, K., & Curtin-Boles, H. (2013). Exploring positive masculine development in African American men: A retrospective study. *Psychology of Men & Masculinity, 14*(1), 7-15. http://dx.doi.org/10.1037/a0029662

Rochlen, A. B., McKelley, R., & Pituch, K. (2006). A preliminary examination of the Real Men. Real Depression campaign. *Psychology of Men & Masculinity, 7*(1), 1-13. http://dx.doi.org/10.1037/1524-9220.7.1.1

Rochlen, A. B., Whilde, M. R., & Hoyer, W. D. (2005). Real men. Real depression: Overview, theoretical implications, and research considerations. *Psychology of Men & Masculinity, 6*(3), 186-194. http://dx.doi.org/10.1037/1524-9220.6.3.186

Rolfe, A., Dalton, S., Krishnan, M., Orford, J., Mehdikhani, M., Cawley, J., & Ferrins-Brown, M. (2006). Alcohol, gender, aggression and violence: Findings from the Birmingham Untreated Heavy Drinkers Project. *Journal of Substance Use, 11*(5), 343-358. http://dx.doi.org/10.1080/14659890600677487

Schacht, P. M., Cummings, E. M., & Davies, P. T. (2009). Fathering in family context and child adjustment: A longitudinal analysis. *Journal of Family Psychology, 23*(6), 790-797. http://dx.doi.org/10.1037/a0016741

Schenck, C. E., Braver, S. L., Wolchik, S. A., Saenz, D., Cookston, J. T., & Fabricius, W. V. (2009). Relations between mattering to step- and non-residential fathers and adolescent mental health. *Fathering: A Journal of Theory, Research, and Practice about Men as Fathers, 7*(1), 70-90. http://dx.doi.org/10.3149/fth.0701.70

Shannon, J. D., Tamis-LeMonda, C. S., Lodon, K., & Cabrera, N. (2002). Beyond rough and tumble: Low-income fathers' interactions and children's cognitive development at 24 months. *Parenting Science and Practice, 2*(2), 77-104. http://dx.doi.org/10.1207/S15327922PAR0202_01

Sheeber, L. B., Johnston, C., Chen, M., Leve, C., Hops, H., & Davis, B. (2009). Mothers' and fathers' attributions for adolescent behavior: An examination in families of depressed, subdiagnostic, and nondepressed youth. *Journal of Family Psychiatry, 23*(6), 871-881. http://dx.doi.org/10.1037/a0016758

Shelton, K. H., & Harold, G. T. (2008). Interparental conflict, negative parenting, and children's adjustment: Bridging links between parents' depression and children's psychological distress. *Journal of Family Psychology, 22*(5), 712-724. http://dx.doi.org/10.1037/ a0013515

Shorey, R. C., Febres, J., Brasfield, H., & Stuart, G. L. (2012). The prevalence of mental health problems in men arrested for domestic violence. *Journal of Family Violence, 27*(8), 741-748. http://dx.doi.org/10.1007/s10896-012-9463-z

Sinkewicz, M., & Lee, R. (2011). Prevalence, comorbidity, and course of depression among black fathers in the United States. *Research on Social Work Practice, 21*(3), 289-297. http://dx.doi.org/10.1177/1049731510386497

Slatcher, R. B., & Trentacosta, C. J. (2011). A naturalistic observation study of the links between parental depressive symptoms and preschoolers' behaviors in everyday life. *Journal of Family Psychology, 25*(3), 444-448. http://dx.doi.org/10.1037 /a0023728

Sun, W., & Starosta, W. J. (2006). Perceptions of minority invisibility among Asian American professionals. *The Howard Journal of Communications, 17*(2)*,* 119-142. http://dx.doi.org/10.1080/10646170600656870

Takeuchi, D. T., Zane, N., Hong, S., Gong, F., Gee, G. C., Walton, E., . . . Alegria, M. (2007). Immigration-related factors and mental disorders among Asian Americans. *American Journal of Public Health, 97*(1), 84-90. http://dx.doi.org/10.2105/ AJPH.2006.088401

Toldson, I. A., & Toldson, I. L. (2006). A father's call: Father-son relationship survival of critical life transitions. In M. E. Connor & J. L. White (Eds.), *Black fathers: An invisible presence in America* (pp. 147-168). Mahwah, NJ: Lawrence Erlbaum.

Tuten, L. M., Jones, H. E., Schaeffer, C. M., & Stitzer, M. L. (2012). *Reinforcement-based treatment for substance use disorders: A comprehensive behavioral approach*. Washington, DC: American Psychological Association.

Van Loon, M. A., Granic, I., & Engels, R. C. M. E. (2011). The role of maternal depression on treatment outcome for children with externalizing behavior problems. *Journal of Psychopathology and Behavioral Assessment, 33*(2), 178-186. http://dx.doi.org/10.1007/s10862-011-9228-7

Weinfield, N. S., Ingerski, L., & Moreau, S. C. (2009). Maternal and paternal depressive symptoms as predictors of toddler adjustment. *Journal of Child and Family Studies, 18*(1), 39-47. http://dx.doi.org/10.1007/s10826-008-9205-2

Weizman, Z. O., & Snow, C. E. (2001). Lexical input as related to children's vocabulary acquisition: Effects of sophisticated exposure and support for meaning. *Developmental Psychology, 37*(2), 265-279. http://dx.doi.org/ 10.1037/0012-1649.37.2.265

Wexler, D. B. (2009). *Men in therapy: New approaches for effective treatment*. New York, NY: W. W. Norton.

Wilson, S., & Durbin, C. E. (2010). Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. *Clinical Psychology Review, 30*(2), 167-180. http://dx.doi.org/10.1016/j.cpr.2009.10.007

Wright, F., O'Leary, J., & Balkin, J. (1989). Shame, guilt, narcissism, and depression: Correlates and sex differences. *Psychoanalytic Psychology, 6*(2), 217-230. http://dx.doi.org/10.1037//0736-9735.6.2.217

APPENDIX A

Field Consultant Consent Form

Interview Consent Form for Field Consultants

I have been informed that this doctoral project interview will be conducted by Elizabeth Newmark, a graduate student at the California School of Professional Psychology at Alliant International University, Los Angeles. I understand that this project is designed to study Paternal Depression: Manifestations and Impacts on the Family, and that I have been contacted by the above student to offer input as a Field Consultant because I have some expertise and/or clinical/professional knowledge about the stated project topic. The purpose of the interview is to not only fill the informational "gaps" that exist in the professional literature about this topic, but to also examine if what is discussed in the research literature is actually being practiced/observed in the community by field professionals.

I am aware that my participation as one of the Field Consultants will involve answering some interview questions (face-to-face, if possible) designed to understand Paternal Depression: Manifestations and Impacts on the Family. I am aware that the interview will be audiotaped -- or conducted via phone or email correspondence, if preferred. The amount of response to these interview questions can be as lengthy or brief as I see appropriate for myself, and I can choose to respond only to those questions that I feel qualified to answer, if needed. The interview process may take approximately 45 minutes of my time to complete, and the interview will be audiotaped (if face-to-face or via phone contact) to ensure its quality and accuracy.

I have been informed that my participation in this study is voluntary and I can withdraw at any time. I understand that this is a professional interview/contact where I will be asked to share my clinical/professional expertise on the stated project topic. Some of the interview contents may be used within the project report as personal communication citations, and my contribution to this study will be appropriately cited within this project.

I am aware that although I may not directly benefit from this study, my participation in this project will further increase knowledge and awareness in the field of psychology **--** specifically, pertaining to Paternal Depression: Manifestations and Impacts on the Family. I understand that I may contact Elizabeth at enewmark@alliant.edu OR his/her project supervisor, Judith Holloway, Ph.D. at 1000 S. Fremont Ave. Unit #5, Alhambra, CA, 91803 or (626) 270-3361 if I have any questions regarding this project or my participation in this interview as a Field Consultant. I understand that at the end of this study, I may request a summary of the results or additional information about the study from the above student.

I have read this form and understand what it says. I voluntarily agree to participate in this professional interview as a part of the student's doctoral project. I understand that I will be signing two copies of this form. I will keep one copy and the student, Elizabeth Newmark, will keep the second copy for his/her records. If I have received this Consent Form and the Interview Questions via email, by returning my answers via reply, I am agreeing to the above-stated conditions.

______________________________ ______________

Participant's Signature Date

______________________________ ______________

Student's Signature Date

APPENDIX B

Questions for Field Consultants

Questions for Field Consultants

1. In your clinical practice, what have you found to be effective in addressing depression in men?

2. In your clinical observations, does the gender of the therapist impact the effectiveness of treatment with depressed men?

3. In your opinion, if treatment involves family therapy, should children receive psychoeducation about the struggles of their depressed fathers? If so, at what age, and how can it be addressed?

4. In your clinical observations, how might a clinician's cultural background impact the course of treatment with depressed men?

5. From your experience, how can clinicians show respect and honor the dignity of their depressed male clients from various cultural backgrounds while directly addressing clinical issues?

6. The correlation between shame and depression, and perceived weakness contributing to shame in men, have interested me. In your experience working with depressed men, what elements or factors in life or society have tended to lead to perceived weakness and shame? Have these factors varied by cultural background?

7. In your clinical practice, what has been your experience of working with shame and vulnerability in men? What has that experience been like for you?

APPENDIX C

Presentation Handouts

Symptoms that may indicate Male-Type Depression:

- Fatigue
- Irritability
- Restlessness
- Somatic symptoms
- Insomnia
- Feeling of emptiness
- Feeling of being "dead inside"
- Decline in vitality
- Antagonistic behaviors (blaming others, angry outbursts)
- Guardedness
- Overemphasis on finding solutions
- Display of hypersexuality
- Working excessively
- Assertion of independence
- Attempts to project the image of strength and control
- Avoidance of emotional content or feelings of weakness
- Use of distractions (e.g., TV, Internet, video games, alcohol, sex)
- Discontentment with the self
- Sensitivity to shame
- Self-criticism
- Withdrawal
- Disruptions in work and/or relationships
- Maladaptive coping skills (e.g., substance abuse, infidelity in intimate relationships)

Paternal Depression:
Manifestations and Impacts on the Family

Elizabeth Newmark, M.A.
Alliant International University
October 30, 2013

Why Study Paternal Depression?

- Danger of suicide
  - 2/3 of those who complete suicide are depressed at time of death (AAS, 2010)
  - Although women are more likely to attempt suicide, **men are four times more likely than women to complete suicide** (CDC, 2012; AAS, 2010)
    - 25,907 male deaths by suicide in 2005, compared with 6,730 female deaths (Caruso, 2005)

Why Study Paternal Depression?

- Paternal depressive symptoms were shown to be correlated with:
  - Child internalizing behavior
  - Child externalizing behavior
  - Poor parenting behavior and negative family environment
  - Intimate partner violence
  - Substance abuse
    - Substance abuse correlated with child maltreatment and child protective service involvement

Overview of Depression in Men

- Reasons male depression tends to be neglected
  - "Women are more likely to be depressed than men"
    - Higher prevalence of treatment-seeking women
  - DSM-IV-TR definition vs. depressive symptoms typically displayed by men
  - Cultural norms and gender expectations about expression of sadness and anger
  - Help-seeking

Overview of Depression in Men

- Coping style of depressed men
  - Reaching out to family/friends
  - Sports/hobbies
  - Use of distractions (work, TV, Internet, sex)
  - Substance use
- Depressed women more often cope through emotional displays (laughing, crying)

Overview of Depression in Men

- Help-Seeking
  - Men across different age groups, nationalities, and ethnic and racial backgrounds are less likely than women to seek help from professionals for physical care, psychiatry, counseling, and substance abuse.
  - Men praised for physical and emotional toughness
  - Depressed men more likely to be rejected by peers if they seek reassurance (Joiner et al., 1992)

Overview of Depression in Men

- http://www.nimh.nih.gov/videos/rmrd/psa_jimmy_2_video.wmv

Overview of Depression in Men

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Previously Attempted Intervention

- Real Men Real Depression campaign – April 2003
  - Intended to target depressed males through community intervention, increase awareness, and improve quality of mental health services
  - PSAs on TV showed men talking about their experiences with depression
  - Interactive website and mass communication (brochures, radio) provided psychoeducation about depression in men, encouraged help-seeking, listed community resources, and described the research

Depressed Fathers as Parents: Parenting styles

- Parenting styles of depressed men
- Positivity suppression
- Positive parenting can combat the effects of depression on parenting
- Problem-solving help from fathers
- Role of the father in the way children experience and perceive their emotions

Depressed Fathers as Parents: Relationship Quality

- Parental hostility
  - Depressed fathers may be at risk for hostility in their parenting
  - This may be particularly difficult for adolescent girls
- Warmth and engagement
  - Depressed fathers may have trouble engaging and showing warmth to their children
  - Adolescent girls vulnerable to the effects of low warmth

Family Process

- Implications of paternal depression in family
- Consequences of marital conflict and negativity on the family system
- Marital distress and depressive symptoms
- Parent-child relationship during times of marital stress is predictive of child outcomes
- Men with dysphoria and conflict

Family Process

- Fathers promote children's cognitive and language development through the following:
  - Warmth, communication, and play in the father-child relationship
  - Use of a variety of language
  - Supportive parenting
  - Low levels of intrusiveness
- Depressed men may need extra help to engage in these positive behaviors

Domestic Violence and Depressed Fathers

- Substance abuse and mental illness: comorbidity and similar presentation
- Depression is directly correlated with intimate partner violence
- The risk of male-perpetrated physical aggression increases significantly with alcohol consumption
- For those with substance addiction, participation in substance treatment decreases the likelihood of domestic violence

Domestic Violence and Depressed Fathers

- Caregiver substance abuse increases the likelihood of:
  - Child protective service involvement
  - Removal of children from the home, placement in foster care
  - Recurrent child maltreatment
- In one analysis, 79% of child protective service cases involved caregiver substance abuse (Besinger et al., 1999)

Cultural Considerations

- Cultural considerations for Black fathers
  - Stereotype of black fathers as absent or underinvolved
    - Struggle to prove their involvement – burnout
  - Pressure to adhere to traditional masculine expectations
- Taboo of suicide in the black community
- http://www.youtube.com/watch?v=WOygMw5wgis

Cultural Considerations

- Black fathers – Clinical implications
  - Family support as a protective factor
    - Higher self-esteem and better quality of life
  - Inquire about their experience of oppression and racism
  - Address the taboo of suicide
  - Important to ask about their own upbringing and role models

Cultural Considerations

- Cultural considerations for Asian American fathers
  - Comprised of many different ethnic backgrounds
  - Traditional family structure
  - Traditional vs. Americanized identities
  - Immigration and acculturation
  - “Model minority”
  - Fathering style

Cultural Considerations

- Helpful strategies for working with Asian American fathers (Oren & Oren, 2010)
  - Select appropriate match between client and therapist
  - Explore impact of immigration & cultural orientation, and impact on relationship with children
  - Convey respect and work carefully with emotions
  - Identify strengths in a culturally appropriate way
  - Explore the construct of masculinity
  - May be helpful to work from a systems framework

Cultural Considerations

- Cultural considerations for Latino fathers
  - Latino American population comprised of various ethnic backgrounds
  - Three significant parental goals: Familismo, Respeto, Educacion
  - Machismo: Positive and negative connotations
  - Acculturation
- http://www.youtube.com/watch?v=xdq5S4isKMU

Shame, Depression, and Culture

- When rapport is built, explore the concepts of strength, weakness, success, and failure
- Explore with clients what defines strength
- Strength defined differently by culture
- Help clients develop self-compassion
- Help family members empathize with the client
- Utilize culturally appropriate community resources

Questions?

APPENDIX D

Presentation Evaluation Form

Presentation Evaluation Form

1. Before the presentation “Paternal Depression: Manifestations and Impacts on the Family,” how familiar were you with the topic?

1	2	3	4	5
Not Familiar		Somewhat Familiar		Very Familiar

2. How much did the presentation increase your knowledge about the topic?

1	2	3	4	5
Not At All		Somewhat		Very Much

3. How useful is this information to you as a clinician of other professional working with men who may show signs of depression?

1	2	3	4	5
Not Useful At All		Somewhat Useful		Very Useful

4. How would you rate the presenter’s overall ability to communicate this information presented?

1	2	3	4	5
Poor		Satisfactory		Very Good

5. How well did the presenter handle questions from the audience?

1	2	3	4	5
Poorly		Satisfactory		Very Well

6. How helpful were the presentation slides?

1	2	3	4	5
Not Helpful At All		Somewhat Helpful		Very Helpful

7. How helpful were the handouts?

1	2	3	4	5
Not Helpful		Somewhat Helpful		Very Helpful

8. What did you like most about the presentation? [Please explain.]

9. What did you like least about the presentation? [Please explain.]

10. How will this information be useful in your work with clients?

11. What suggestions do you have that might help improve this presentation and make it more useful to other clinicians and professionals?

Please answer the following questions about your training and experience:

12a. How many years of clinical experience do you have (including practicum and internship)?

12b. Is your degree/professional training in psychology, marriage and family therapy, social work, or other?

12c. In what capacity do you provide clinical services (e.g., as a practicum student, as an intern, as an unlicensed professional, as a licensed professional)?

APPENDIX E

Vita

Elizabeth R. Newmark, M.A.

EDUCATION

2009-present **California School of Professional Psychology**
Psy.D. Candidate, Family and Child/Couple Emphasis
Alliant International University (APA Accredited)

2005-2009 **University of Washington, Seattle**
B.A. in Psychology

CLINICAL EXPERIENCE

9/2012-07/2013 **Clinical Psychology Internship**, Child and Family Center
Dyadic and family play therapy in Early Childhood Mental Health program to address trauma history and Axis I diagnoses in children ages 0-5. Outpatient mental health services for children 6 and older. Completion of DMH paperwork. Collaboration with inter-disciplinary teams.

8/2012-present **Psychology Assistantship**, Adam W. Sternberg, Psy.D.
Administration, scoring, and interpretation of psychological assessments for a variety of presenting problems.

9/2011-08/2012 **Clinical Psychology Internship,** Alafia Mental Health Institute
Home-based and school-based individual and family therapy for Axis I diagnoses. Completion of DMH paperwork. Collaboration with interdisciplinary teams of psychologists, psychiatrists, social workers, and teachers to provide optimal care for clients.

08/2010-06/2011 **Practicum,** The Help Group
Home-based individual and family therapy for a wide range of Axis I diagnoses. Completion of DMH paperwork. Co-facilitated social skills group for girls 6-8 with ADHD and learning disabilities. Collaboration with interdisciplinary teams to provide care for clients. Administered, scored, and interpreted psychoeducational assessment batteries to determine eligibility for academic accommodations.

07/2009-07-2009 **Elective Internship,** Baron School for Exceptional Children
Assisted teachers in managing disruptive or maladaptive behaviors. Helped children manage frustration and practice social skills.

04/2008-06/2009 **Classroom Aide**, Experimental Education Unit, U.of Washington

Assisted teachers in managing disruptive or maladaptive behaviors. Helped children manage frustration and practice social skills.

RESEARCH EXPERIENCE

1/2009-7/2009 **Research Assistant,** Simons Simplex Study
University of Washington
Assisted with administrative tasks and the videotaping of sessions for a study examining the genetics of families with only one autistic child.

8/2008-12/2008 **Directed Reading**, Raphe Bernier, Ph.D.
University of Washington
Read research articles concerning etiology, identification, diagnosis and treatment of autism. Articles assigned by a University of Washington professor in the autism research center.

1/2008-3/2008 **Research Assistant,** Integrative Orientation
University of Washington
Ran subjects for a study examining the effects of success and failure on self-esteem.

6/2007-6/2008 **Research Assistant,** Carlson Child Development Lab
University of Washington
Assisted with coding and administrative tasks in a study examining delay of gratification of young children.

OTHER RELEVANT EXPERIENCE

10/2005-3/2008 **Tutor,** Greenlake Elementary School
6/2003-8/2003 **Teacher's Assistant**, Lankershim Elementary School
6/2002-8/2002 **Teacher's Assistant,** Maggy Haves Preschool

PROFESSIONAL ORGANIZATIONS

2010-present American Psychological Association (Graduate Student Affiliate)
2008-2009 Psi Chi
2008-2009 National Society of Collegiate Scholars

HONORS/AWARDS

2009-2010 Dean's Award of Excellence, California School of Professional Psychology
2005-2009 Dean's List, University of Washington